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# Illinois Medical Journal

OFFICIAL JOURNAL OF THE  
ILLINOIS STATE MEDICAL SOCIETY

Volume 161, No. 1, January 1982

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*Annual  
Legislative  
Update*

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**INDICATIONS:** *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

**CONTRAINDICATIONS:** Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-

mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

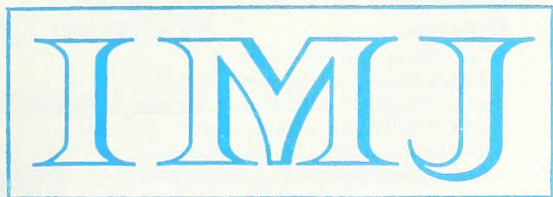
**PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. PML.



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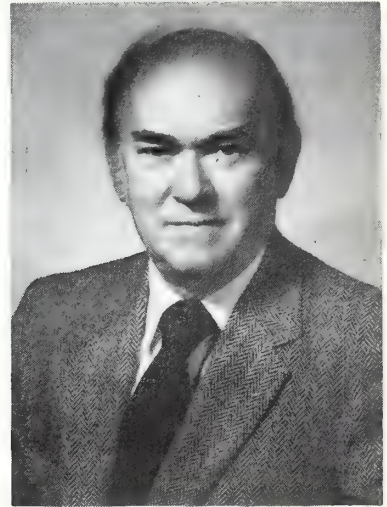
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# President's Page

## Success Is Our Problem



The ubiquitous discussions on the cost of medical care are justified due to the magnitude and trend of present health care costs. Certainly, some costs may be excessive and some may be unnecessary. After all, neither our society nor our medical system is perfect.

Having made note of this in one analytical part of my mind, I continue to suffer a growing sense of discomfort that stems from several origins:

- The knowledge that medicine is doing a superb job of prolonging life and improving the quality of that life.
- The realization that 80% of health care costs are generated because medicine has made more years of life possible. Since 1930, the life span has risen from about 50 to 73 years. Those last 20-25 years account for most of the increase in cost.
- The realization that we now identify and treat problems early—sometimes in a life-sparing manner that mandates additional treatment later. A myocardial infarction at age 45 that survives to have coronary bypass grafts will later require continued monitoring, probably angiograms and exercise stress tests, and possibly subsequent per cutaneous angioplasty or a second graft.
- Subsequent costs would have been avoided had that 45 year old male expired with the initial event.

Patients have expectations, too. With their increasing knowledge of things medical, they now present early with a vague sense of “not feeling well”—indistinct and global symptoms. Despite a lack of physical findings, they expect to be told with exquisite definition, “what’s going on.” They know we have sophisticated testing procedures and expect these to be activated in their behalf.

We in medicine feel obliged to do so, *not* because we bow to high patient demands, but because we, too, hope to find disease in its earliest phase and are cognitively and morally reluctant to ignore the challenge. This early detection mandates early and therefore long-time follow-up and/or treatment, and a corresponding long-time cost.

The risk-free ethic of our society also must be recognized. All expect to be unerringly diagnosed, treated, and managed through at least two generations, or litigation may occur. To achieve nearly 100% correctness in this *and* the next generation is costly business. But, that is society’s (our) decision. Yet when we attempt to honor that decision, society is reluctant to pay the price. Society’s decision-making generally is either out of synchronization, or, at the minimum, schizophrenic.

Additionally, society has not made the decision of “how much health care for whom.” Great Britain has made the decision not to perform heart transplants for their citizens. Sweden prohibits renal transplants for patients over a certain age. Medicine in the United States has an ever-expanding capability at an ever-increasing cost and the medical profession will not—cannot—make that decision.

In the U.S., these hard decisions have not been made by our governmental policy makers. However, “not to decide is to decide,” and that decision has been honored by the medical profession.

It seems unfair that, after making that decision, government and others complain to us about its cost.

A handwritten signature in dark ink, appearing to read "Fred Z. White".

Fred Z. White, M.D., President



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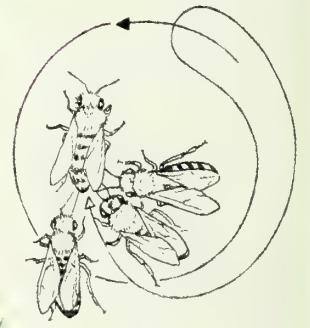
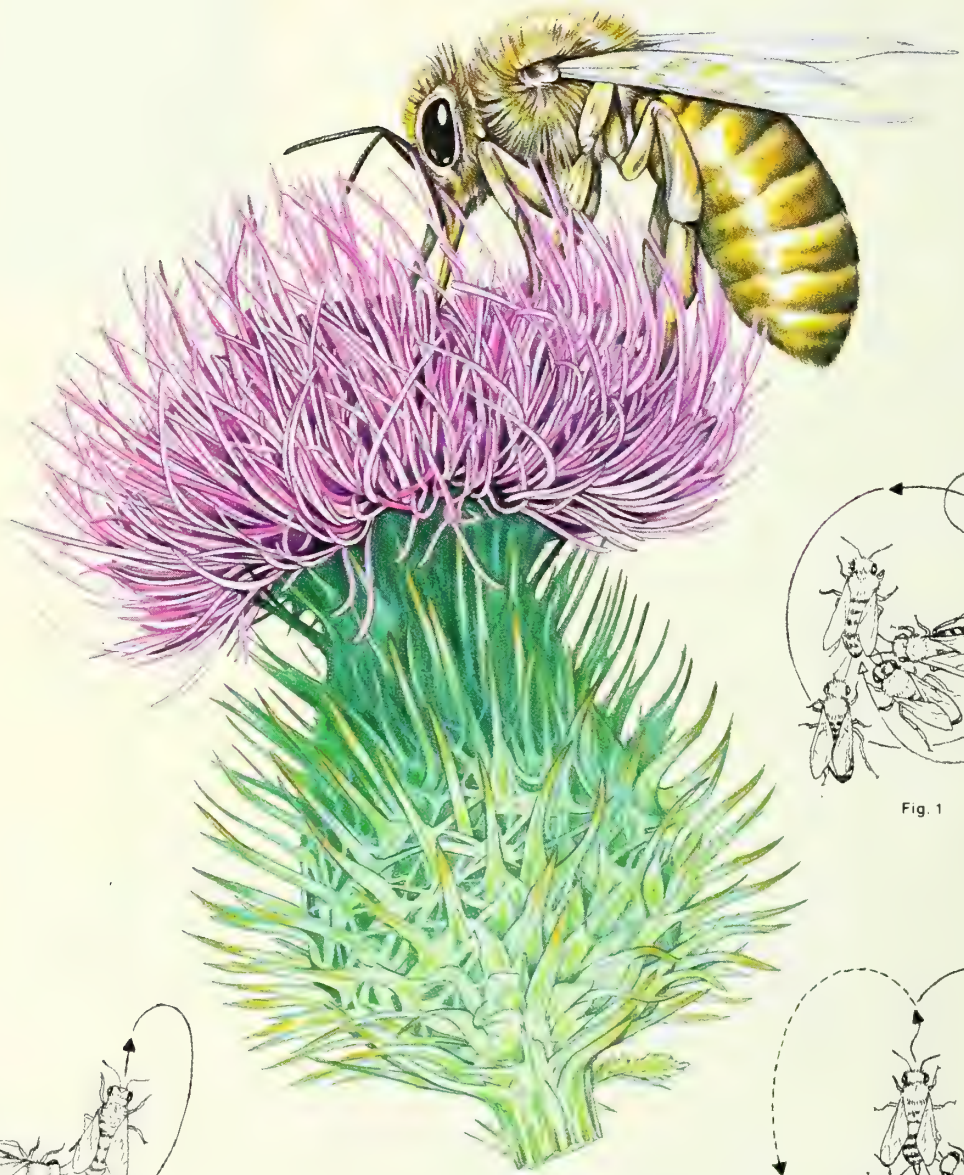


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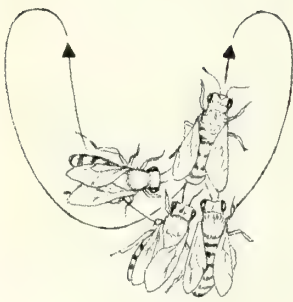


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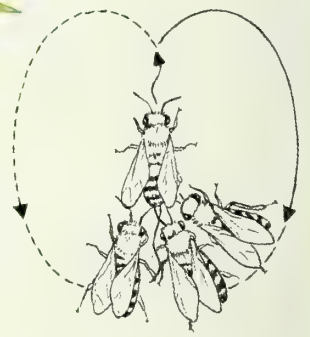


Fig. 2

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\*Hannemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. C., Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. R.: Digital Plethysmography For Assessing Erythrityl Tetranitrate Bioavailability. Clin Pharmacol and Ther 29:35-39, 1981.

## Cardilate® (erythrityl tetranitrate) Oral Tablets

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**INDICATIONS:** Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris rather than for the treatment of the acute attack of angina pectoris since its onset is somewhat slower than that of nitroglycerin.

**CONTRAINDICATIONS:** Idiosyncrasy to this drug.

**WARNING:** Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

**PRECAUTIONS:** Intraocular pressure is increased therefore caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.

**ADVERSE REACTIONS:** Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine and many other agents. An occasional individ-

ual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur.

### DOSAGE AND ADMINISTRATION

Oral / Sublingual Tablets: Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg. prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

### HOW SUPPLIED:

CARDILATE (Erythrityl Tetranitrate) TABLETS (Scored)  
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# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This month's Viewbox was contributed by Richard A. Cooper, M.D., assistant professor of radiology, Loyola University Medical Center, Maywood.*

*The patient is a 54 year old female who complains of urinary incontinence. She is otherwise asymptomatic. Six months ago, she underwent a course of radiation therapy for carcinoma of the uterine cervix. The X-ray is from an IVP.*



Figure 1

## Your diagnosis?

1. Vesico-vaginal fistula
2. Cystocele
3. Recurrent carcinoma
4. No abnormality seen on IVP

*(Continued on page 35)*

# new basis for understanding anxiety suggests new reasons for choosing tranxene <sup>IV</sup> clonazepam dipotassium

4306CB

is an artist's representation of a neuron with the recently discovered binding site for benzodiazepines. The theory<sup>1</sup> explains the role of benzodiazepines in anxiety management. It also suggests that if a long-acting drug is suddenly withdrawn, it may provoke neuronal excitability possibly experienced by some patients as "withdrawal symptoms." In contrast, a short-acting benzodiazepine gives the system more time to adapt by tapering slowly. Thus, distress on discontinuation may be minimized.



## Starts promptly\*

TRANXENE starts to work fast, with pharmacologic effects observed in about 30 minutes. Euphoria is rarely a problem, and there's less risk of reinforcing bad behavior.<sup>2</sup>

Reported in normal volunteers 30 minutes after dosing. TRANXENE Drug Monograph 97-0185.

On kinetics of an agent can be closely determined cannot at present be related to therapeutic effects.

## Stops gently\*\*

A long-acting benzodiazepine, such as TRANXENE, has a kind of built-in tapering-off action; withdrawal reactions when they occur may be subtle, of longer duration and much attenuated.<sup>3</sup>

## Works smoothly

TRANXENE works short-term — studies show dependable, smooth calming action with 83% to 90% overall therapeutic response.<sup>4</sup> Oversedation is seldom seen and the incidence of serious side effects has been low.

For references and a brief summary of prescribing information, please see accompanying column.



**When short-term therapy  
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**INDICATIONS** — For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

**CONTRAINDICATIONS** — Known hypersensitivity to the drug. Acute narrow angle glaucoma.

**WARNINGS** — Not for use in depressive neuroses or psychotic reactions. Caution patients against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

**Pregnancy and Lactation:** Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

**PRECAUTIONS** — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

**ADVERSE REACTIONS** — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function, decreased hematocrit, decreased systolic blood pressure.

**INTERACTIONS** — Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

**OVERDOSAGE** — Take general measures as for any CNS depressant.

**SUPPLIED** — TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

**REFERENCES** — 1. Snyder SH: *Anxiety: The Therapeutic Dilemma*, No. 2, Management Alternatives, Monograph 97-0544, 1981, p 6-7. 2. Mielke DH, Goethe JW: *Anxiety: The Therapeutic Dilemma*, No. 2, Management Alternatives, Monograph 97-0544, 1981, p 31. 3. Hollister LE: *Anxiety: The Therapeutic Dilemma*, No. 2, Management Alternatives, Monograph 97-0544, 1981, p 13. 4. TRANXENE Drug Monograph 97-0185, 1981, p 15.



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**Specialty Review in Pathology: Clinical**

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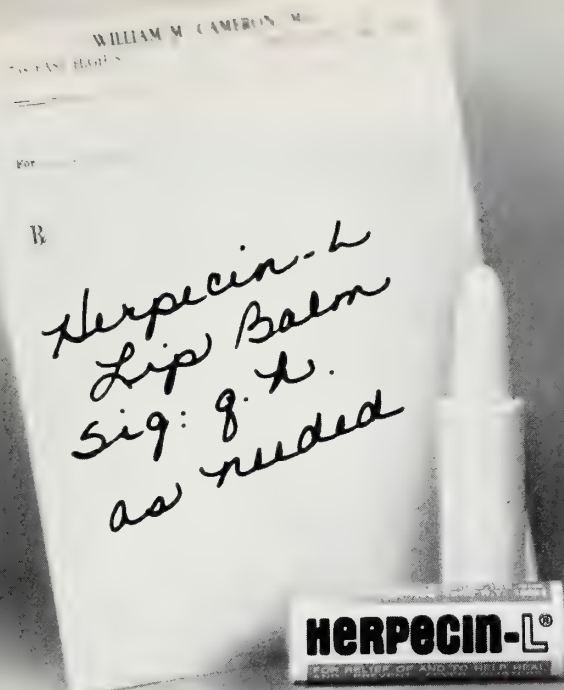
**Specialty Review in Urology**

April 19-23, 1982

*For further course offerings, information and  
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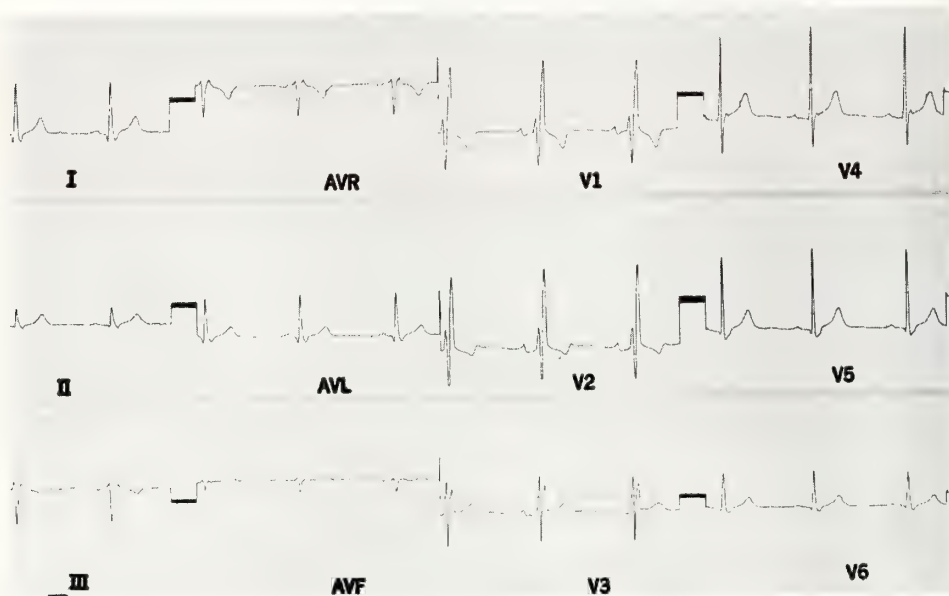
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# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a seventy-year-old man who was admitted to the orthopedic service for a total hip replacement. His complaints are pain and stiffness of the hip. X-rays confirm the impression of severe degenerative arthritis. His past medical history is significant for double aortocoronary bypass surgery and right carotid endarterectomy three years ago. His preoperative cardiac catheterization demonstrated normal left ventricular function. Postoperatively he did well and had no angina or other cardiac symptoms. He takes no cardiac medications and his last ECG two years ago was normal. His cardiac examination is normal. The question to the medical consultant involves surgical clearance and medical management over the period of surgery. A twelve lead ECG is taken.*



## Questions:

### 1. The ECG shows:

- A. Abnormal left axis deviation.
- B. Accelerated idioventricular rhythm.
- C. Complete left bundle branch block.
- D. Complete right bundle branch block.
- E. Abnormal right axis deviation

### 2. The following statement(s) is/are true:

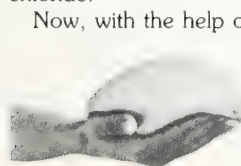
- A. The patient should be cleared for hip replacement surgery.
- B. Do not clear for hip surgery because of great risk
- C. Clear for the proposed surgery but place a temporary demand pacemaker first.
- D. Digitalize the patient preoperatively.
- E. Follow the postoperative ECGs and cardiac enzymes.

(Continued on page 31)



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# Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 E. Monroe St., Suite 3510, Chicago IL 60603; (312) 236-6110

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

## FEBRUARY

### Regional Anesthesia

**For:** Anesthesiologists. Lecture, Feb. 15 (5 days), Chicago. **Speaker:** Alon Winnie, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 20. **Credit:** Category 1, 45 hours.

### Anesthesiology

#### Management of Common Joint Problems

**For:** MD's. Symposium, Feb. 17, 1:00 p.m., Marion. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Medicine

### Surgery

#### Specialty Review in Surgery, Part II

**For:** General Surgeons. Lecture, Feb. 22 (11 days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$600. **Reg. limit:** 400. **Credit:** Category 1, 100 hours.

### Illinois Anesthesia Study Commission

**For:** Anesthesiologists. Symposium, Feb. 11, Chicago. **Sponsor:** Illinois Society of Anesthesiologist, Inc., c/o Office of the Secretary, Michael Reese Hospital, 29th St. and Ellis Ave., Chicago 60616. **Reg. deadline:** none. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Susan Polk, MD. **Phone:** 312/791-2544.

### Anesthesiology

### Neurology

### Surgery

#### Basic Science of Neurology

**For:** Neurologists, Psychiatrists. Lecture, Feb. 22 (5 days), Chicago. **Speaker:** John Hughes, MD, PhD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 150. **Credit:** Category 1, 42 hours.

### Sports Medicine

**For:** MD's. Symposium, Feb. 16, 7:00 p.m., Effingham. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Cardiovascular

#### Symposium on Peripherovascular Diseases

**For:** MD's. Symposium, Feb. 5, 12, 19 & 26, 11:00 a.m., Oak Park. **Sponsor:** Oak Park Hospital, 520 S. Maple, Oak Park. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Charles Weigel, MD. **Phone:** 312/366-7870.

### Oncology

### Surgery

#### Extracapsular Cataract Extraction & Posterior Chamber Lens Implantation Workshops

**For:** Ophthalmologists. Workshops, Feb. 10, Chicago. **Speaker:** Andrew Lewicky, MD. **Sponsor:** Grant Hospital, 550 W. Webster Ave., Chicago 60614. **Cosponsor:** Rush Medical School. **Reg. deadline:** 2/1. **Fee:** \$300. **Reg. limit:** 20. **Credit:** Category 1, 8 hours. **Contact:** Sharon Smith. **Phone:** 312/883-2112.

### Dermatology

#### Office Dermatology

**For:** MD's. Lecture, Feb. 23, 6:30 p.m., Kankakee. **Speaker:** Evelyn Anderson, MD. **Sponsor:** Riverside Medical Center, 350 N. Wall St., Kankakee 60901. **Fee:** \$3. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Lisa Mitchell. **Phone:** 815/933-1671.

### Ophthalmology

#### Ophthalmology Grand Rounds

**For:** Ophthalmologists. Grand Rounds, Feb. 3, 10, 17 and 24, 4:00 p.m., Chicago. **Sponsor:** Dept. of Ophthalmology, U of I, 1855 W. Taylor, Chicago 60612. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Jacob Wilensky, MD. **Phone:** 312/996-7030.

### Urology

#### AUA Home Study Series IV

**For:** Urologists. Home study courses. **Sponsor:** American Urological Assn., CME, P. O. Box 25147, Houston, TX 77005. **Fee:** \$100, members; \$110, non-members. **Credit:** Category 1, 48 hours. **Contact:** Mona Grimmer. **Phone:** 713/790-6070.

### Otolaryngology

### Family Practice

#### Advances in Family Practice

**For:** FP's, GP's. Lecture, Feb. 15 (5 days), Chicago. **Speaker:** Harry Marchmont-Robinson, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Reg. limit:** 150. **Credit:** Category 1, 35 hours.

#### Annual Mid-Winter Symposium on Practical Surgical Problems in Otolaryngology

**For:** Otolaryngologists. Symposium, Feb. 22-26, Aspen, CO. **Sponsor:** Lutheran General Hospital, 1775 Dempster St., Park Ridge 60068, Rm. 415 South. **Reg. deadline:** none. **Fee:** \$325. **Reg. limit:** 300. **Credit:** Category 1, 30 hours. **Contact:** Robert Meyers. **Phone:** 312/696-6365.

### Pediatric Hematology

### Geriatrics

#### Communication Problems in Geriatrics

**For:** FP's, GP's. Symposium, Feb. 17, St. Louis, MO. **Sponsor:** St. Louis University, School of Medicine, 1402 S. Grand St., St. Louis, MO 63104. **Reg. deadline:** 2/10. **Fee:** TBA. **Reg. limit:** none. **Credit:** AAFP Prescribed, 7 hours; Category 1, 7 hours. **Contact:** John Grellner. **Phone:** 314/664-9800 x 127.

#### Transfusion Therapy in Children

**For:** Pediatricians, Hematologists, Pathologists. Lectures, Feb. 9-11, Alamos Resort Hotel, Scottsdale, AZ. **Sponsor:** Lutheran General Hospital, 1775 Dempster St., Park Ridge 60068. **Reg. deadline:** 11/15/81. **Fee:** \$175. **Reg. limit:** 150. **Credit:** Category 1, 18 hours. **Contact:** Dorothy Petersen. **Phone:** 312/696-6986.

### Medical/Legal

#### Medicine and the Law

**For:** MD's. Symposium, Feb. 11, 1:00 p.m., Pittsfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Surgery

#### Surgical Correction of Congenital Deformities

**For:** MD's. Lecture, Feb. 19, 8:00 a.m., Chicago. **Speaker:** Gary Burget, MD. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Reg. deadline:** none. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Sharon Smith. **Phone:** 312/883-2112.

### Surgery

#### Specialty Review in Neurological Surgery

**For:** Neurosurgeons, Neurologists. Lecture, Feb. 5 (10 days), Chicago. **Speaker:** Leonard Krantzler, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$600. **Reg. limit:** 250. **Credit:** Category 1, 101 hours.

## MARCH

### Cardiology

#### Arrhythmias and Cardiac Ischemia: Diagnosis and Management

**For:** GP's, FP's, Internists. Seminar, March 19-20, Marriott Hotel, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Dr. E., Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours; IACEP, 13 hours. **Contact:** Stephen Mattingly. **Phone:** 800/525-8651 x 123.

### Cardiovascular Disease

#### Current Concepts in Therapeutic Drug Monitoring

**For:** GP's, Pathologists, Psychiatrists, Internists. Conference, March 25, St. Louis, MO. **Sponsor:** School of Medicine, St. Louis University, 1402 S. Grand, St. Louis, MO 63104. **Reg. deadline:** 3/18. **Fee:** \$45. **Reg. limit:** none. **Credit:** Category 1, 7 hours; AAFP Prescribed, 7 hours. **Contact:** John Grellner. **Phone:** 314/664-9800 x 127.

### Computers

#### Choosing & Using a Computer System in Private Practice

**For:** MD's. Seminar, March 12-13, Chicago Marriott. **Speaker:** Ronnie Beth Bush, Ph.D. **Sponsor:** UHS/CMS, 3333 Green Bay Road, North Chicago 60064. **Fee:** \$295. **Credit:** Category 1, 16 hours. **Contact:** Connie Scott. **Phone:** 312/683-2066.

### Hypertension

#### The Role of Beta Blockers in the Management of Essential Hypertension

**For:** MD's. Lecture, March 19, 8:00 a.m., Chicago. **Speaker:** Gerald Glick, MD. **Sponsor:** Grant Hospital, 550 West Webster, Chicago 60614. **Reg. deadline:** none. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Sharon Smith. **Phone:** 312/883-2112.

**Symposium on Infectious Diseases**

**For:** MD's. Symposium, March 5, 12, 19, and 26, 11:00 a.m., Oak Park. **Sponsor:** Oak Park Hospital, 520 S. Maple, Oak Park. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Charles Weigel, MD. **Phone:** 312/366-7870.

*Internal Medicine***State & National Board Review, Clinical**

**For:** MD's. Lecture, March 29 (6 days), Chicago. **Speaker:** Henry Jeffay, PhD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 90. **Credit:** Category 1, 56 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800

*Internal Medicine***State & National Board Review, Basic**

**For:** MD's. Lecture, March 22 (6 1/2 days), Chicago. **Speaker:** Henry Jeffay, PhD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 90. **Credit:** Category 1, 62 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800

*Medicine***Dermatologic Therapeutics for the General Practitioner**

**For:** GP's. Symposium, March 12, 8:00 a.m., Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 7 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

*Medicine***Viral and Bacterial Pulmonary Disease**

**For:** MD's. Symposium, March 11, 1:00 p.m., Sparta. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

*Medicine***Cardiology Seminar-at-Sea**

**For:** Cardiologists. Course, March 3-13, Caribbean. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 48 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

*Medicine***Oral Medicine**

**For:** MD's. Symposium, March 18, 1:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

*Occupational Lung Disease***International Conference on Occupational Lung Disease**

**For:** MD's. Symposium, March 24-27, Hyatt Regency, Chicago. **Sponsor:** American College of Chest Physicians, 911 Busse Hwy., Park Ridge. **Reg. deadline:** none. **Fee:** \$200. **Reg. limit:** none. **Credit:** Category 1, 22 hours. **Contact:** Dale Braddy. **Phone:** 312/698-2200.

*Ophthalmology***6th Annual Ophthalmology Current Concepts Seminar '82**

**For:** Ophthalmologists. Workshops, March 25-26, Madison, WI. **Sponsor:** U of WI-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** \$155. **Reg. limit:** none. **Credit:** Category 1, TBA; AOA, TBA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

*Ophthalmology***Grand Rounds**

**For:** Ophthalmologists. Grand Rounds, Wednesdays, March 3, 10, 17, 24 & 31, 4:00 p.m., Chicago. **Sponsor:** Dept. of Ophthalmology, U of I, 1855 W. Taylor, Chicago 60612. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Jacob Wilensky, MD. **Phone:** 312/996-7030.

*Ophthalmology***Symposium and Workshop on Laser Therapy of Glaucoma**

**For:** Ophthalmologists. Symposium and Workshop, March 25-26, Chicago. **Sponsor:** Dept. of Ophthalmology, U of I, 1855 W. Taylor, Chicago 60612. **Fee:** \$400; \$200 (Symposium only). **Reg. limit:** Symposium—none; Workshop—32. **Credit:** Category 1, 12 hours. **Contact:** Jacob Wilensky, MD. **Phone:** 312/996-7030.

*Pathology***Lung Pathology**

**For:** Pathologists, Chest Physicians. Symposium, March 29-April 2, Ramada O'Hare Inn, Des Plaines. **Sponsor:** American College of Chest Physicians, 911 Busse Hwy., Park Ridge 60068. **Reg. deadline:** none. **Fee:** AACP member, \$550; non-member, \$600. **Reg. limit:** none. **Credit:** Category 1, 38 hours. **Contact:** Dale Braddy. **Phone:** 312/698-2200.

**Pediatric Neurology—Review & Clinical Update**

**For:** Pediatricians. Lecture, March 1 (3 days), Chicago. **Speaker:** Lawrence Tomasi, MD, PhD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$250. **Credit:** Category 1, 24 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

*Pediatrics***Recent Advances in Health Care Diagnosis**

**For:** GP's, FP's. Symposium, March 31-April 1, St. Louis, MO. **Sponsor:** St. Louis University, School of Medicine, 1402 S. Grand, St. Louis, MO 63104. **Reg. deadline:** 3/24. **Fee:** TBA. **Reg. limit:** none. **Credit:** Category 1, 7 hours; AAFP Prescribed, 7 hours. **Contact:** John Grellner. **Phone:** 314/664-9800 × 127

**Specialty Review in Psychiatry**

**For:** Psychiatrists, Neurologists. Lecture, March 15 (5 days), Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$425. **Reg. limit:** 100. **Credit:** Category 1, 44 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

*Psychiatry**Pulmonary Disease***COPD**

**For:** MD's. Lecture, March 23, 6:30 p.m., Kankakee. **Speaker:** Arthur Banner, MD. **Sponsor:** Riverside Medical Center, 350 N. Wall St., Kankakee 60901. **Fee:** \$3. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Lisa Mitchell. **Phone:** 815/933-1671.

*Pulmonary Medicine***Chronic Obstructive Pulmonary Diseases Symposium**

**For:** MD's. Symposium, March 4-5, Madison, WI. **Sponsor:** U of WI-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** \$180. **Reg. limit:** none. **Credit:** Category 1, 13 hours; AOA, 13 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

*Surgery***Pediatric Aspects of Head & Neck Surgery**

**For:** MD's. Symposium, March 5, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

*Surgery***Fiberoptic Esophagogastric Endoscopy**

**For:** Surgeons, Internists. Lecture, March 8 (2 1/2 days), Chicago. **Speaker:** C. Thomas Bombeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

*Urology/Sexual Dysfunction***Incontinence and Sexual Dysfunction Seminar**

**For:** MD's. Course, March 19-20, Chicago. **Speaker:** William Furlow. **Sponsor:** American Urological Assn. Office of Education, P. O. Box 25147, Houston, TX 77005. **Reg. deadline:** 3/18. **Fee:** \$230, members; \$260, non-members. **Reg. limit:** 150. **Credit:** Category 1, 16 hours. **Contact:** Alice Henderson. **Phone:** 713/790-6070.

**APRIL***Cardiac Rehabilitation***State of the Art—1982**

**For:** MD's. Symposium, April 22-23, St. Louis, MO. **Sponsor:** St. Louis University, School of Medicine, 1402 S. Grand, St. Louis, MO 63104. **Reg. deadline:** 4/15. **Fee:** \$175. **Reg. limit:** 120. **Credit:** Category 1, 14 hours. **Contact:** John Grellner. **Phone:** 314/664-9800 × 127.

*Cardiovascular Diseases***Symposium on Cardiology**

**For:** MD's. Symposium, April 2, 16, 23, and 30, 11:00 a.m., Oak Park. **Sponsor:** Oak Park Hospital, 520 S. Maple Ave., Oak Park. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Charles Weigel, MD. **Phone:** 312/366-7870.

*Endocrinology***Endocrinology & Diabetes**

**For:** Internists. Course, April 28-30, Indianapolis, IN. **Sponsor:** American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. **Fee:** \$200, members; \$150, associates; \$265, non-members. **Reg. limit:** 200. **Credit:** Category 1. **Contact:** Maxine Topping. **Phone:** 215/243-1200.

**Medical Ethics**

**For:** MD's. Lecture, April 27, 6:30 p.m., Kankakee. **Sponsor:** Riverside Medical Center, 350 N. Wall St., Kankakee 60901. **Fee:** \$3. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Lisa Mitchell. **Phone:** 815/933-1671.

*Medicine***Dermatology**

**For:** Dermatologists. Symposium, April 23, Springfield. **Sponsor:** SIU School of Medicine, CME, P.O. Box 3926, Springfield 62708. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

*Ophthalmology***Grand Rounds**

**For:** Ophthalmologists. Grand Rounds, April 14, 21 and 28, 4:00 p.m., Chicago. **Sponsor:** Dept. of Ophthalmology, U of I, 1855 W. Taylor, Chicago 60612. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Jacob Wilensky, MD. **Phone:** 312/996-7030.

*Plastic & Reconstructive Surgery***Primary Care of Facial Injuries**

**For:** Ophthalmologists. Grand Rounds, April 16, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 7 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

*Psychiatry***Anxiety & Depression**

**For:** MD's. Symposium, April 20, 7:00 p.m., Centralia. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

*Radiology***Radiologic Approaches to the Chest and Abdomen**

**For:** Radiologists, Oncologists, Surgeons, Pulmonary Disease Specialists. Lecture/workshop, April 28-30, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** \$310. **Credit:** Category 1, 2 hours; ACR. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

*Surgery***Peri-Operative Complications**

**For:** MD's. Symposium, April 22, 1:00 p.m., Pittsford. **Sponsor:** SIU School of Medicine, CME, P.O. Box 3926, Springfield 62708. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

*Surgery***Pain**

**For:** MD's. Symposium, April 2, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

*Surgery***Breast and Endocrine Disease**

**For:** Surgeons, Oncologists. Symposium, April 16-17, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** \$155. **Credit:** Category 1, 9 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

*Surgical Trauma*

**For:** Surgeons. Case presentation, 2nd Friday of mo., 4:30-6:00 p.m., Chicago Athletic Association, Chicago. **Sponsor:** CITC Group. **Reg. deadline:** none. **Fee:** none. **Reg. limit:** none. **Credit:** pending. **Contact:** Peter Geis, MD. **Phone:** 312/531-3454

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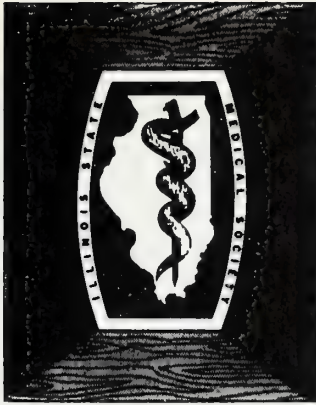
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# IMJ

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## Metastatic Carcinoma Simulating Bell's Palsy

BY JOYCE M. LITVIN, M.A., M.D. AND JAMES M. CUTTONE, M.D.  
LIBERTYVILLE, ILLINOIS AND ATLANTA, GEORGIA

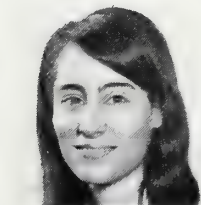
*This is a report of two patients with signs of Bell's Palsy who were found to have metastatic carcinoma which caused their seventh nerve paralysis. Metastatic lesions causing facial paralysis are said to be extremely rare<sup>1</sup> and are usually reported in the otolaryngological literature. We report these cases as a reminder that an apparent Bell's Palsy may be a sign of a life threatening disease.*

**Case 1:** A 75 year old female presented to our eye clinic with a three month history of right facial palsy. Cortisone injections were tried elsewhere without success. Previous eye history included a right sided Bell's Palsy seven months before, which spontaneously resolved in one week. Past medical history included a radical mastectomy on the left side for an infiltrating ductal carcinoma five months ago. A recent bone scan had shown generalized bony metastasis including skull, spine, pelvis and proximal long

bones. Bilateral internal acoustic meatus tonography revealed diffuse mottled increase in density. The patient was asymptomatic except for her VII nerve palsy.

Eye examination revealed a right VII nerve palsy with ectropion of the lower eyelid. The patient was unable to blink spontaneously on the right side and Bell's phenomena was seen only with forceful eyelid closure. The remainder of the eye examination was unremarkable except for punctate staining inferiorly on the right cornea. Treatment included artificial tears every two hours while awake and methycellulose ointment with a patch at night. Upon recommendation of her oncologist, the patient was given palliative super voltage radiation therapy of 4,025 rads in 23 fractions over 30 days to her right masseter area. At her last visit, appreciable clinical improvement was noted of her palsy and corneal staining was greatly diminished.

**Case 2:** A 72 year old man presented with a weakness of the left orbicularis oculi muscle, pain in the left mastoid, absent corneal reflex on the left and absent taste sensation of the left anterior two-thirds of the tongue. Previous medical history revealed that he had had a transurethral prostatectomy for carcinoma four years earlier. Since then he had been treated with Stilbesterol®.



**JOYCE M. LITVIN, M.A., M.D.,** is an ophthalmologist in solo private practice affiliated with Condell Hospital in Libertyville. At this writing, Dr. Litvin was affiliated with the Loyola University Stritch School of Medicine, Maywood.

**JAMES M. CUTTONE, M.D.,** is a board certified ophthalmologist specializing in pediatric ophthalmology. Presently located in Atlanta, Georgia, Dr. Cuttone is a former assistant clinical professor and director of pediatric ophthalmology and strabismus, department of ophthalmology, Loyola University Stritch School of Medicine. He has also served as a clinical instructor for both the UI Eye and Ear Infirmary and the UI Center for Craniofacial Anomalies.



TABLE 1				
	Cases of Metastasis to the Temporal Bone	Breast as Primary	Prostate as Primary	Bell's Palsy Described
1922 Asai <sup>2</sup>	1	1		
1965 Shapoory <sup>5</sup>	1	1		
1965 Friedman and Osborn <sup>6</sup>	1	1		
1967 Maddox <sup>7</sup>	29	4	2	
	(Breast and Hypernephroma (6) stated as being the most common)			
1968 Schucknecht et al <sup>8</sup>	73			
	(not broken down as to primary)			
1969 Jones <sup>9</sup>	1	1		specifically stated none present
	(biopsy proven he states that he reports the 6th case in the literature from breast)			
1969 Cawthorne <sup>10</sup>	3	3		
1971 Adams <sup>11</sup>	10	1		
1975 Thomas <sup>12</sup>	1	1		specifically stated none present
1976 Breadon <sup>1</sup>	3	3	3	3

X-rays showed generalized metastatic bone lesions. Bone scan showed focal regions of increased uptake in activity in the skull including the left temporal bone. A left VII nerve palsy was diagnosed. It was thought it could be a Bell's Palsy but probably was related to metastatic disease to the left masseter area. The patient was treated under the direction of his oncologist by radiation therapy. Initially he had 1,400 rads to his whole skull and later 2,700 rads to the left mastoid area. It was given in 16 fractions over 23 days. After radiation there was marked clinical improvement in his facial palsy.

### Literature Review

A review of the American literature (with the exception of the first case reported by Asai as quoted in Lodge<sup>2</sup>) of metastasis to the temporal bone is presented in Table 1. Two other authors have been interested in this topic and did reviews. In 1976, Hill<sup>3</sup> looked at the world literature and found that out of 102 cases of metastasis to the temporal bone, 18 were from breast, and 4 were from prostate. In 1977, May *et al*,<sup>4</sup> did a prospective study of 500 patients with facial paralysis evaluated from 1966-1975. After a complete otoneurologic evaluation was done, an underlying cause was found in about 20%. Tumor accounted for 30% of those patients with recurrent unilateral facial palsy.

### Summary

We have reported two cases of metastatic disease to the temporal bone that presented with known carcinoma and what initially appeared as a Bell's Palsy. The patients were found to have metastasis causing their VII nerve symptoms that readily responded to radiation therapy. ◀

### Acknowledgements

We wish to thank Michael Fine, M.D., our neuroradiologist for his help and Herbert Reisel, M.D., oncologist, for referral of one of our patients. Special thanks to Ms. Jan Mixter, our medical bibliographer.

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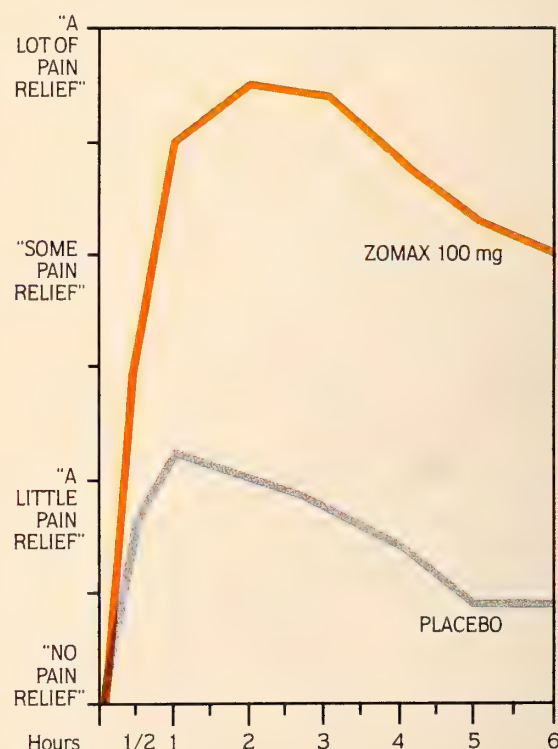


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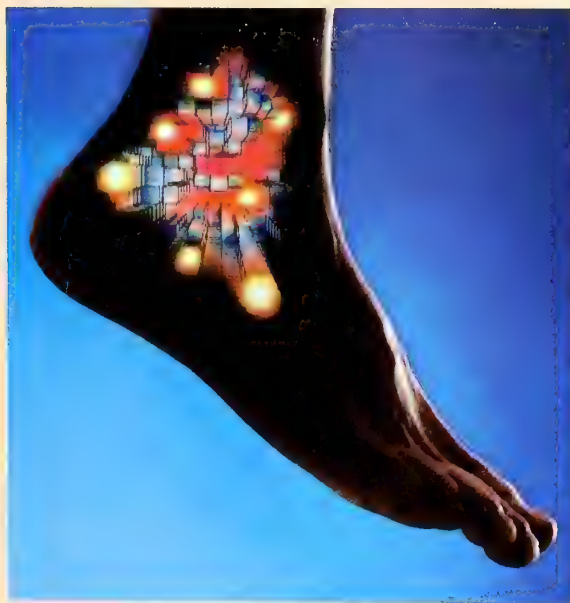
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"...from the standpoint of both effectiveness and tolerability, zomepirac is a useful alternative to existing analgesic agents for the management of acute orthopedic pain."<sup>3</sup>



## No evidence of addiction potential

"...abrupt change from oral zomepirac to aspirin demonstrated no evidence of withdrawal symptoms."<sup>4</sup>

"...no evidence of development of tolerance during extended therapy [one year] with zomepirac."<sup>5</sup>

## Low incidence of side effects

The most frequently reported side effects were gastrointestinal. The most common of these was nausea. Urinary tract signs and symptoms were more frequent in ZOMAX-treated patients than in aspirin patients. ZOMAX should be given under close supervision to patients with a history of upper gastrointestinal tract or renal disease, or for those treated for longer than six months (see warnings and precautions).

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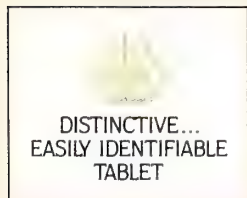


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**INDICATIONS AND USAGE:** ZOMAX (zomepirac sodium) is indicated for the relief of mild to moderately severe pain.

**CONTRAINDICATIONS:** In patients who have previously exhibited intolerance to it, in patients in whom aspirin and other nonsteroidal, anti-inflammatory drugs induce bronchospasm, rhinitis, urticaria, or other sensitivity reactions.

**WARNINGS:** Give under close supervision to patients with a history of upper gastrointestinal tract disease and only after consulting the ADVERSE REACTIONS section. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported.

In clinical studies in patients receiving long-term zomepirac sodium treatment for up to 2 years, peptic ulcers were reported at an incidence of almost one percent. Gastrointestinal bleeding without evidence of peptic ulceration has been reported at an incidence of about 3 per 1000.

Because of animal tumorigenicity findings (see PRECAUTIONS, Carcinogenesis section) and the possibility of adverse effects on the urinary tract from prolonged use in humans (see PRECAUTIONS), caution should be exercised in considering ZOMAX for chronic use.

**PRECAUTIONS, General:** In a 6-month clinical trial, urinary tract signs and symptoms of dysuria, cystitis, urinary frequency, hematuria, pyuria, and urinary tract infection appeared at a greater incidence in the ZOMAX patients (6.8%) than in aspirin patients (1.4%). The probability that the difference observed in these two incidence rates is due to chance alone is 0.03. Although the cause of these signs and symptoms and their causal relationship to zomepirac sodium have not been adequately established, use with caution in patients treated for longer than 6 months. (Also see next paragraph for long-term renal effects in animals).

Long-term toxicological studies have been done in rodents and primates. Metabolic studies with zomepirac sodium suggest that monkeys provide the best animal model for man. In rats, dose-related renal papillary necrosis and papillary edema were observed. In mice, renal papillary necrosis was observed, usually associated with advanced amyloidosis. In two 12-month studies in monkeys, there were occurrences of multifocal chronic nephritis characterized by interstitial scarring in monkeys receiving 40 mg/kg/day of zomepirac sodium, and milder interstitial nephritis and edema after 20 mg/kg/day. Nephrotoxicity was not observed in monkeys given 10 mg/kg/day for 1 year.

As with other drugs which inhibit prostaglandin biosynthesis, elevations of BUN and serum creatinine have been reported. Therefore, periodic kidney function tests are recommended for those patients undergoing long-term treatment. Since zomepirac is eliminated primarily by the kidneys, patients with impaired renal function should be closely monitored and lower doses of zomepirac sodium used.

Mild peripheral edema has been reported in some patients receiving long-term therapy. Therefore, use with caution in patients with fluid retention, hypertension, and heart failure.

ZOMAX, like aspirin, inhibits platelet function and prolongs bleeding time; therefore, patients who have coagulation disorders should be carefully observed when ZOMAX tablets are administered.

Because of ocular changes observed in animals with other nonsteroidal anti-inflammatory drugs, it is recommended that ophthalmologic examinations be carried out if visual symptoms develop.

The antipyretic and anti-inflammatory activity of ZOMAX may reduce fever and inflammation, thus diminishing their utility as diagnostic signs in detecting complications of presumed non-infectious non-inflammatory painful

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#### DRUG INTERACTIONS:

The *in vitro* binding of zomepirac to human plasma proteins is decreased by salicylate at salicylate concentrations as low as 5 mcg/ml, and the decrease is concentration dependent. *In vitro* studies indicated that at therapeutic concentrations of salicylates, the binding of zomepirac was reduced from approximately 98% to 96-93%. Since there have been no controlled clinical trials to demonstrate whether or not there is any beneficial effect or harmful interaction with the use of ZOMAX (zomepirac sodium) in conjunction with aspirin, the combination is not recommended.

**CARCINOGENESIS, MUTAGENESIS, AND IMPAIRMENT OF FERTILITY:** In two 2-year studies in rats at doses up to 7.5 mg/kg/day (approximately the human dose in mg/kg), the incidence of adrenal tumors was increased. In two 18-month studies in mice at doses up to 10 mg/kg/day, zomepirac sodium did not show evidence of tumorigenicity.

Reproductive studies revealed no impairment of fertility in animals, but zomepirac sodium did have an effect on parturition.

**PREGNANCY AND NURSING MOTHERS:** Because of the animal tumorigenicity findings (see PRECAUTIONS, Carcinogenesis section) ZOMAX is not recommended during pregnancy or for treatment of nursing mothers.

**PEDIATRIC USE:** ZOMAX is not recommended for use in children because of animal tumorigenicity findings (see PRECAUTIONS, Carcinogenesis section) and the possibility of adverse effects on the urinary tract from prolonged use in humans (see PRECAUTIONS).

#### ADVERSE REACTIONS:

##### Incidence Greater Than 1%

The following adverse reactions occurred more frequently than 1 in 100 in the approximately 1000 patients receiving therapy of one week or longer. The incidence of adverse reactions for patients receiving short-term therapy was in nearly all cases substantially lower.

**Gastrointestinal:** Nausea 12% (6% in short-term therapy), gastrointestinal distress\*, diarrhea\*, abdominal pain\*, dyspepsia\*, constipation\*, flatulence\*, vomiting\*, gastritis, and anorexia.

**Central Nervous System:** Dizziness\*, insomnia\*, drowsiness, paresthesia.

**Cardiovascular/Respiratory:** Edema\*, elevated blood pressure\*, cardiac irregularity, palpitations.

**Dermatologic:** Rash\*, pruritus, skin irritation, sweating.

**Body as a Whole:** Asthenia\*.

**Urogenital:** Urinary tract infection\*, urinary frequency, elevated BUN, elevated creatinine, vaginitis.

**Special Senses:** Tinnitus, taste change.

**Psychiatric:** Nervousness, anxiety, depression.

\*Incidence 3% to 9% of patients.

**Incidence Less Than 1%**  
(Causal Relationship Probable)

**Urogenital:** Hematuria.

**Dermatologic:** Urticaria.

**Gastrointestinal:** Peptic ulcer, gastrointestinal bleeding.

**Body as a Whole:** Periorbital edema.

**Incidence Less Than 1%**  
(Causal Relationship Unknown)

**Body as a Whole:** Chills.

**Gastrointestinal:** Liver function abnormalities.

**DRUG ABUSE AND DEPENDENCE:** ZOMAX is a non-narcotic, non-addicting analgesic drug.

**OVERDOSAGE:** The absence of experience with acute overdosage precludes characterization of sequelae and assessment of antidotal efficacy at this time. It is reasonable to assume, however, that the standard practices of gastric evacuation, activated charcoal administration, and general supportive therapy would apply.

Animal studies have indicated that bicarbonate alkalization significantly enhances zomepirac elimination from the plasma and suggest that this measure would have benefit in a clinical overdosage situation.

**DOSAGE AND ADMINISTRATION.** The recommended oral dose of ZOMAX (zomepirac sodium) tablets is 100 mg every 4 to 6 hours as required. In mild pain, 50 mg (one-half tablet) every 4 to 6 hours may be adequate.

In well-controlled studies, single doses larger than 100 mg have not been more effective than 100 mg and are not recommended. Doses exceeding 600 mg per day have not been studied and are not recommended for even acute use. In treatment exceeding 3 months duration, doses greater than 400 mg per day have not been studied and are not recommended.

Patients who receive long-term treatment should be periodically monitored (see PRECAUTIONS). Since antacids do not interfere with the bioavailability of zomepirac, ZOMAX may be administered with antacids (other than sodium bicarbonate) if gastrointestinal symptoms occur.

ZOMAX is not recommended for use in children (see PRECAUTIONS, Pediatric Use).

**REFERENCES:** 1. deAndrade JR, Honig S, Ciccone WJ, et al: Clinical comparison of zomepirac with pentazocine in the treatment of postsurgical pain. *J Clin Pharmacol* 20(4, part 2): 292-297, April 1980. 2. McMillen JI, Urbaniak JR, Boas R: Treatment of chronic orthopedic pain with zomepirac. *J Clin Pharmacol* 20(5-6, part 2): 385-391, May-June 1980. 3. Mayer TG, Ruoff GE: Clinical evaluation of zomepirac in the treatment of acute orthopedic pain. *J Clin Pharmacol* 20(4, part 2): 285-291, April 1980. 4. O'Brien CP, Minn FL: Evaluation for withdrawal symptoms following chronic zomepirac administration. *J Clin Pharmacol* 20(5-6, part 2): 397-400, May-June 1980. 5. Honig S: Preliminary report: Long-term safety of zomepirac. *J Clin Pharmacol* 20(5-6, part 2): 392-96, May-June 1980.

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\*ZOMAX is a nonsteroidal, anti-inflammatory agent which has been developed as an analgesic. It also possesses antipyretic activity.

## Part Two

# Dreams And Dreaming

BY ABD EL AZIZ A. SALAMA, M.D./SPRINGFIELD

*This article completes a two part series initiated last month to examine dream phenomena. Readers may also wish to refer to the author's earlier review paper, "Sleep, Physiology and Disorders," which was published in the January, 1981, issue of IMJ.*

Dream images are so unique that unless some repetitive elements or themes can be found to exist and to have the same meanings whenever they occur, it is difficult to obtain agreement on what they represent. This problem has most often been approached by manipulating the presleep situation to induce some known specific effect, such as sexual or aggressive feelings, or by studying the dream following some naturally occurring high arousal situation.<sup>1</sup>

Freud<sup>2</sup> described recurring dreams in 1900 without elaborating on their genesis. In "Beyond the Pleasure Principle," he attempted to explain clinical findings and observations that were not in keeping with the pleasure principle. He suggested that people who have experienced a trauma which they cannot resolve and work through unconsciously, recreate that trauma in a repetitive manner in an attempt to master it. This principle is known as the "Repetition Compulsion," and is felt to be the mechanism by which one experiences repetitive distressing dreams.

The dreams a person recognizes as familiar from previous experience have been studied

among those with traumatic war neuroses and in the aged with chronic brain syndromes. The dreamer in these dreams was reported to be helpless and overwhelmed, unable to master the difficulty or complete the action intended.<sup>3</sup> The dreams were mirroring the inability of the subject to deal effectively with some aspect of the environment during his waking life.

At times patients will seek evaluation of a recurring dream while denying other symptoms. In such cases the dream is highly symbolic, with multiple past traumas condensed, displaced and symbolized in it. The dream may so disguise the conflict and so bind the anxiety that the patient remains relatively asymptomatic aside from the anxiety associated with the dream's occurrence. Such dreams may suggest an intense unresolved conflict requiring intervention to prevent the breakthrough for more significant psychopathology.

The recall of dreaming is related to the affect level being experienced during the prior waking period. Following stressful events and upset moods we are aware of dreaming more; when things are going well we are less aware of dreaming. Repetitive dreams seem to originate at different periods around points of stress.

### Dream Mirrors

Psychoanalytic literature contains few references to dreams containing mirrors, despite the frequency of references to the analyst as a mirror since Freud's suggestions on technique.<sup>4</sup> In his paper on "The Uncanny," Freud refers to Rank's concept of the double as originally representing an insurance against the destruction of the "ego," an "energetic denial of the power of death." Freud elaborates: "The invention of doubling as a preservation against extinction has its counterpart in the language of dreams, which is fond of representing castration by a doubling or multiplication



**ABD EL AZIZ A. SALAMA, M.D.,** is an assistant professor, Southern Illinois University School of Medicine, department of psychiatry. He is certified by the American Board of Psychiatry, a Diplomate in Psychiatry of the Royal College of Physicians and Surgeons and a member of the Royal College of Psychiatrists of England.



of a genital symbol.” That doubling can be used as a defense against loss is inherent in the concepts of both Freud and Rank. In 1920, Freud referred to a child who made an effort to deal with a brief separation from his mother by making his own image alternately appear and disappear in a mirror. Freud also concluded that mirrors appear in dreams at turning points in the analysis, when the integrative functions of the ego have become strong enough to deal with the anxiety aroused by the emergence into consciousness of major repressed conflicts.

Miller wrote in 1948 that mirror dreams occur in narcissistic patients when the integrative function of the ego is increased, and that these dreams represent a struggle of the ego to master reality.<sup>5</sup>

Eisnitz, stated that mirror dreams represent an attempt at defense against narcissistic mortification from the superego, from the analyst, or from reality. In the case of the superego threat, the threatening part of the superego is split off, and projected to the mirror.<sup>6</sup>

The mirror in the mirror dream seems to represent a highly polished surface of the dream screen. One might visualize a movie screen where events and characters are portrayed as the more usual kind of dream representations. If one visualizes a movie screen where these characters are portrayed and places a mirror on it in one's mind's eye, then he comes to the surface of the screen itself. In this the mirror is an extension of the screen.<sup>7</sup>

It is true that mirror dreams represent a regressive partial reunion with the protective mother to allay guilt and reassure against object loss in response to aggression mobilized by an object conflict. Mirror dreams then appear at times of crisis, characteristically after a threatening interpretation. There is a continuum between mirror dreams in which the subject sees himself in the mirror and emerges and those in which a distorted reflection or no reflection at all is seen in the mirror (or multiple mirror). The latter type of mirror dream is followed by terror and sometimes by dreams of monsters, by hypochondriacal concerns and the emergence of poorly integrated motor activity. It's suggested that mirror dreams are an important psychological landmark and that they afford an exceptional opportunity for studying the development of integrative capacities for early interaction.

### **Anxiety Dreams:**

The content of dreams can be affected by inflicting intensive pain on the dreamer or inflicting on him intensive emotional pain during the pre-

sleep period. Even suggestion of mild anxiety or anger usually retrieved old memories that appeared in the dream, which usually are related to an old solution that once offered relief in an angry or anxious situation.

Freud<sup>2</sup> included anxiety dreams with the manifest content of having failed an examination. The subject awakens with a feeling of relief: “It was only a dream actually, since I have already passed.” Freud said: “In the case of those who have obtained a university degree, this typical dream is replaced by another one which represents them as having failed in their university finals, and it is in vain that they object, while they are still asleep.” Such dreams, according to Freud: “appear when the dreamer has some responsible activity ahead of him, and is afraid there may be a ‘fiasco,’ a situation that revives memories of punishment for evil deeds of childhood.” He explained: “The parent as a feared figure is replaced by a schoolmaster and then by an examination.” Since the subject of the examination in the dream is one which the dreamer has already passed, the dream serves as a consolation, *i.e.*, “Do not be afraid of tomorrow, you are a graduate already.” Anxiety in a dream suggests a kind of contradiction; how can a dream, a hallucinatory wish fulfillment, be ridden with anxiety? Altman<sup>8</sup> explains: The ego's task is to preserve sleep by gratifying wish-impulses in a hallucinatory manner. The ego is not necessarily antagonistic to primitive wish impulses, libidinal or aggressive. The ego censors objectionable wishes, at the same time it gratifies them by distorting them with dream mechanisms, ego defenses, or both.

On the other hand, punishment, guilt, remorse, or anxiety, will be introduced by the conscience (superego) to prevent the gratification of a dream wish. An overly severe conscience puts too great a strain on the ego, whose job is to maintain sleep, and is in itself a measure of emotional disturbance. The mature superego or conscience is less punitive and can express approval in a dream, though it maintains its restrictive, punitive and protective functions.

Anxiety which emanates solely from the ego is felt either because the dreamer does not want the wish to be fulfilled<sup>3</sup> or because the wish impulse has escaped the ego's distorting censor and the undisguised wish-fulfillment is gratified or nearly gratified.

Freud has also said that the anxiety dreams<sup>9</sup> are those which have undergone the least amount of distortion. With a strong repressed wish, and a lack of strong defenses to ward it off, the ego makes a last ditch stand to maintain sleep by letting anxiety become part of the dream. If the

wish impulse continues to clamor for gratification the ego stops trying to resolve the conflict by compromise and the subject awakens.

### **Frightening Dreams, Nightmares and Night Terrors**

In a study of hospitalized psychiatric patients<sup>10</sup> it was found that patients who took their tricyclic or neuroleptic drugs at one bed time dose reported more frightening dreams than did those taking divided daily doses. One way to explain this finding, is the rise in blood levels of the drug during the night. Also patients who awaken often during the night, remember more dreams. Lipman<sup>11</sup> characterizes the nightmare as an intense, soul-shaking horror, wherein the feeling is usually out of proportion with what is happening in the dream. People, animals, or shapes can terrify or overwhelm the dreamer, who wants to escape but often cannot. When the dream is repetitious, sometimes the dreamer will purposefully awake, stopping the nightmare before it begins.

Murderer impulses directed against the dreamer usually give rise to the nightmare<sup>11</sup> but these impulses can be directed against someone else in the dream.

Altman explained that in the nightmare, part of the ego stands apart from the dream and its conflict. It views all aspects of the situation with relative neutrality and identifies actions that will go against its own interests.<sup>8</sup> French added that the ego says to itself: "If I act on this wish, I must expect certain consequences."<sup>12</sup> In that sense, the ego has a practical grasp of the dream situation. But if the ego views only a part of the conflict, the forbidden aspect of the wish is not taken into account and the dream action is motivated by forbidden impulses which lead to punishment or the fear of it.

Night terrors occur in all ages, but mostly in children, and were found to occur in 3% of healthy children. The subject wakes up from his sleep, disturbed by the content of his dream and extremely frightened. During night terror, the subject cannot be fully aroused. People are either not recognized or are of minor significance as compared with the impact of the dream. The dream seems to continue, even though the subject's eyes are open. He incorporates some pieces of his actual environment into the dream, or projects the dream into his environment. Several approaches were advised for treatment, including Imipramine,<sup>®13</sup> and Diazepam<sup>®</sup>. They suppress night terrors in one to two weeks, but recurrence is possible after discontinuation of treatment. Methylphenidate in morning and noon doses was also reported to be helpful.<sup>14</sup> Hypnosis, with im-

agery of the dangerous situation, was also reported as successful.<sup>15</sup>

### **Catastrophic Dreams**

Catastrophic dreams represent a rationalization for retreat from danger, which can signal the possibility of a flight from analysis.<sup>5</sup>

The anxiety response which could not be expressed in the real life situation is usually produced by the ego in a subsequent dream. The presence of anxiety in the dream stimulates the ego of the dreamer to institute defensive operations which directly modify the traumatic events, or failing that, it causes the dreamer to awaken prior to the denouement. The amnesia of the traumatic event in the daytime and the recurrence of the traumatic event in the dream suggest that dreams following a trauma provide psychological representation. The daytime amnesia was attributed to the powerful effects of the unexpected and overwhelming shock which acts as if it were an anaesthetic insofar as it inhibits the higher levels of the mind which one required to create imagery. There are several examples of post-traumatic dreams which were blank, presumably because the dreamer's ego in them had failed in its task of translating the imageless trauma into imagery.

### **Dreams of Fragmentation and Death**

Certain varieties of unusual dreams have been reported in a number of schizophrenic and manic depressive patients, in which the dreamer visualizes a part of his own body (other than teeth or hair) as severed or separated from the rest of the body. These dreams of body fragmentation occur occasionally in non psychotic close relatives of schizophrenic or manic-depressive patients, including certain "high-risk" children.<sup>16</sup> While these dreams are not of diagnostic help when they occur at the height of a psychotic episode, they may provide the first clue of vulnerability to psychosis when they are reported early in treatment, especially of seemingly neurotic office patients.

Closely akin to dreams of fragmentation are those depicting the actual death of the dreamer. Such dreams were considered impossible by Freud,<sup>17</sup> because of the alleged inability of the ego to conceive its own death; nevertheless, it happens occasionally in psychosis-prone patients.

### **Uses of Dreams in Psychotherapy**

Since the 1900 publication of Freud's *INTERPRETATION OF DREAMS*, the dream has been inextricably linked to psychotherapy. Although dream interpretation originated in psychoanalytic practice as a means of learning more about in-



trapsychic processes, it is now, to some degree, part of all dynamic psychotherapies. However, in psychotherapy, insight is the primary goal. Many derivatives of unconscious conflicts may be dealt with within limitations of the dimension of the treatment: the patient's degree of ego strength; his ability to tolerate regression; the goals of treatment; the time allocated to deal with the dream material; and the anticipated duration of treatment. As a general rule, the therapist should not deal with more than he and the patient can work through effectively in the treatment situation.

At the onset of supportive or short-term treatment, it is generally not desirable to ask that the patient report his dreams. An early deep exploration of the dream may lead to material that should remain out of awareness; in short-term therapy there is rarely enough time to adequately deal with the dream. However, in the hand of an experienced therapist, the dream can effectively be used in crisis-oriented therapy.<sup>18</sup>

In intensive or long-term therapy, the therapist may attempt to strengthen the therapist-patient relationship by avoiding interpretations of unconscious material. Discussion may be limited to the patient's conscious and preconscious attitudes toward the therapist as a real person who can then be better perceived as a helper. Dreams with an incestuous content for example, can be interpreted in this way, explaining the erotic content as symbolic of a feeling of friendliness. This not only supports the relationship, but also keeps out of awareness thoughts that might prove to be overwhelming to the patient. It also strengthens the patient's defense of repression, intellectualization and rationalization.

It would not be useful to make interpretation of a dream that is completely unrelated to the patient's conscious concern. Similarly, it would be unwise to interpret the dream in terms of a global reconstruction of childhood events prior to a long and careful review of those events.

A distinction is drawn between the use of the dream in supportive psychotherapy as contrasted with insight-oriented psychotherapy. In the former, the dream serves supportive functions if used at all. In insight oriented psychotherapy, the goals are to develop better awareness by the patient of himself. Understanding of the dream is reached by inserting it into the context of the patient's psychological life. What is actually communicated to the patient will be keyed to the psychological surface that the patient represents.

In all therapeutic situations, including analysis, the therapist thinks about the dream in the same way, but uses his understanding of the dream in

different ways. He or she examines it from a variety of viewpoints: what it might reveal of unconscious conflicts, what it reveals about ego and superego functions, its relationships to the patient's interaction with the external world, and his position in the therapeutic situation of transference, resistance and termination.

### **Dreams in Conjoint Marital Therapy**

Dreams can enrich and enliven conjoint marital therapy. Not every couple in conjoint therapy can benefit from working with their dreams. If the therapist shows interest, dreams reported will aid in better recall and communication of meaningful feelings.<sup>19</sup> Particular parts of a dream can bring reaction from the dreamer, the spouse and the therapist. They facilitate discussion of sexual feelings and otherwise assist the search for honesty, clarity and closeness.

### **Dream Review In Psychoanalytic Groups**

As group therapy developed, different techniques were used to deal with dreams brought up in therapy sessions. Norman Locke<sup>20</sup> agrees with the idea that group reported dreams are less obscure, with latent and manifest content more closely related. He comments on the suggestive nature of the therapist's interest in dreams, a phenomenon common to groups and individual therapy: patients will report their dreams to please an interested therapist. Locke uses the dream of one person as a protective screen for the association of others. The symbolic content can serve to enhance communication with others, whose reactions to the dream are based on their own thoughts, feelings, fantasies and conflicts. While others help in the interpretation of the dream for the individual, they reveal their own unconscious issues.

Vivian Gold<sup>21</sup> outlines four issues which should be addressed in the study of dreams in groups. First, how can dreams be used to enable patients to become aware of and integrate repressed and defended aspects of themselves? Second, is there anything special or unique about the "Group Dream," a dream in which the group appears in some form, in elucidating covert group purposes? Third, in what way does a past group session act as a residue which then appears in a later dream? Fourth, how does the dream reveal the group interactions and how does the dream relate to the group's themes and conflicts?

### **Hypnosis and Dreaming**

Schroeter<sup>22</sup> demonstrated that nocturnal dream reports may be influenced by hypnotic suggestion. He noted that morning recall of dreaming was

often consistent with presleep suggestions administered during hypnosis. This was confirmed by Stoyva<sup>23</sup> who reported that subject's dream reports were in accordance with administered suggestion. He also noted that presleep hypnotic suggestions reduced the REM sleep time. Albert and Boone<sup>24</sup> added that, if it is possible to modify dream content with posthypnotic suggestion, one might also attempt to change the quantity of dreaming through hypnosis. Elimination of dream enhancement may provide basic insights into the functional properties of dreams, and these effects might also provide beneficial information concerning treatment of various sleep disorders. For example, it may be possible to treat dream-interruption insomnia through suggestions of dream facilitation. Therapy for narcolepsy and sleep walking might also be aided by the presentation of post-hypnotic suggestions that are properly worded.

### Telepathy and Dreaming

Dreams experienced by two persons simultaneously (or almost) that have individual or extremely similar content has been reported, especially between parent and child. Paranormal dreams commonly involve persons who have

deep emotional ties. These ties are not based on genetic relationships. Husbands and wives reported paranormal dreaming with the same frequency as parents and children or siblings. The importance of emotional ties between the dreamer and the person dreamed about is reinforced by reports of dreams that some patients have had about their therapists.<sup>25</sup> To qualify as paranormal, a dream must include some unusual content of which the dreamer could not be normally aware.

Ethemwald<sup>26</sup> postulated that ESP begins as a natural function of the mother-child unit. It is interesting that children aged 3½-5½ years were found to perform significantly better on tests of ESP when their own mothers were senders or agents than when the senders were the mothers of other children.<sup>27</sup>

Experimental evidence has demonstrated that therapeutic dreams occur in controlled environments during REM periods.<sup>28</sup> Telepathic dreams rarely occur between persons who dislike each other.

### References

A complete list of references for "Dreams and Dreaming: Part Two," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago IL 60603.

## EKG

(Continued on page 14)

**Answers: 1. D. 2. A. E.**

The ECG shows complete right bundle branch block. There is a sinus rhythm with a PR interval of .18 seconds and a QRS duration of .12 seconds. The QRS complex is essentially positive in lead II and negative in lead AVF so the mean QRS axis in the frontal plane is approximately -15°. Abnormal left axis deviation would be greater than -30°. There is an RSR' in leads V<sub>1</sub>V<sub>2</sub>V<sub>3</sub> and a slurred S wave in leads I, AVL, V<sub>5</sub> and V<sub>6</sub>. There is no ECG evidence for recent or old myocardial infarction. Therefore, the patient has developed complete right bundle branch block sometime since his last ECG two years ago. He has no symptoms of congestive heart failure so digitalis would not be needed. If complete right

bundle branch block developed acutely with a myocardial infarction, in-hospital mortality is 22% and the first year follow-up mortality is 24%. These figures are worse if additional abnormal left or right axis deviation or congestive heart failure are present. (*Circulation* 58:689, 1978). Pacemakers may be required here. In this case, the right bundle branch block developed without symptoms. Acquired right bundle branch block without evidence of other heart disease may be benign. Recently, a Baltimore longitudinal study reported no adverse effect on cardiovascular morbidity or mortality in twenty six clinically healthy men with right bundle branch block followed over seven years (*Circulation* 64(4):IV-249, 1981). A review of his old coronary angiogram and, in some institutions, a CAT scan of the aortacoronary bypass grafts for patency could be performed. Our patient was cleared for hip surgery. Postoperative cardiac enzymes and ECGs were acceptable. His postoperative course was uneventful. ◀



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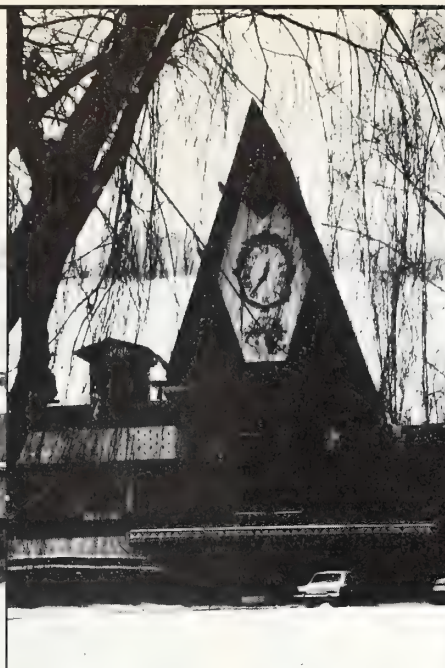
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Dr. Robert Wilson	
TRI-STATE DENTAL	1/10-1/15, '82
Dr. Donald DeCenso	
OHIO VETERINARY MEDICAL ASSOC.	1/24-1/29, '82
Dr. George Norris	
FAMILY PRACTICE UP- DATE CONFERENCE	1/31-2/5, '82
Janet Johnson	
MICHIGAN OPTOMETRIC ASSOCIATION	2/14-2/19, '82
Dr. Phillip Irion	
BOYNE WINTER IMAGING SEMINAR	2/14-2/19, '82
Dr. Robert Bree	

## BOYNE MOUNTAIN Boyne Falls, MI

MID-WINTER MEDICAL MEETING	1/24-1/29, '82
Dr. Michael Hughes	
MICHIGAN HEART ASSOCIATION	1/31-2/5, '82
Eleanor Peterson, R.N.	

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Hillsboro Clinic		
MONTANA PHYSICAL THERAPY ASSOC.	1/22-1/24	State
Diane C. Allen, LPT		
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Dept. of Radiology		
Columbus Hospital		
MONTANA ACADEMY OF OPHTHALMOLOGY	2/11-2/14	Regional
Dr. Kenneth Younger		
MONTANA ACADEMY OF DERMATOLOGY	1/12-2/15	Regional
Dr. Ronald Orman		
CARDIOLOGY SEMINAR	2/13-2/20	National
Dr. Sidney Goldstein		
Head-Division of		
Cardiovascular Medicine		
Henry Ford Hospital		
TRI-STATE DENTAL/ MEDICAL	2/20-2/27	Regional
Hugh Henning, DDS		
TOPICS IN INTERNAL MEDICINE	2/23-2/28	National
Frances Burt		
ANESTHESIOLOGY SEMINAR	2/24-2/28	National
Mrs. Phyllis Sherburne		
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Columbus Hospital		

OB/GYN SOCIETY	3/3-3/7	Regional
Dr. John Browne		
BIG SKY UROLOGICAL SOCIETY	3/4-3/7	National
Dr. Robert Towers		
WESTERN ORTHOPEDIC ASSOCIATION	3/5-3/7	Regional
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CONTINUING EDUCA- TION SEMINAR, MEDICAL COLLEGE OF GEORGIA	3/7-3/13	National
Morris Travel		
MONTANA SOCIETY OF DENTISTRY FOR CHILDREN	3/18-3/21	State
Dr. Thomas Wickliffe		
PULMONARY DISEASES COURSE	3/20-3/27	National
Terrie vanAllen		
Extended Programs in Medical Education		
"ACHA Hospital Liability and the Quality of Patient Care"	1/16-1/23, '82	National
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**GENESEO:** Population 8,000, trade area - 29,000. Rich farming area. Downtown office fully equipped. Hospital - ultra modern. 25 miles east of quad cities - population 400,000. Quality community needing a quality physician. Contact: Mrs. A. W. Wellstein, 9 Maplewood, Geneseo 61254 (309-944-2530). (2)

**GREENVILLE:** Established Medical Group seeking additional physician in Family Practice. Excellent salary first year with full partnership the following year. 45 miles from St. Louis on Interstate 70. Population area 15,000. CONTACT: Charles R. Daisey, M.D., 308 W. College, Greenville 62646 (618-664-2531). (1)

**KEWANEE:** 108 bed community hospital involved in an expansion program is interested in recruiting family practitioners to our service area of 35,000 population. Several practice opportunities exist in group or solo practices. The population centers in the service area range from 15,000 in population and less. Contact Harold L. Bischoff, Kewanee Public Hospital, 719 Elliott Street, Kewanee 61443 (309) 853-3361. (4)

**LINCOLN:** 20 miles from Southern Illinois University School of Medicine in Springfield and halfway between St. Louis and Chicago on I55. Need two family practice physicians for growing practice. Office facilities available with 10 man medical group. Contact Mary Richter, 311 Eighth, Lincoln 62656. (217/732-9681). (4)

**MACOMB:** GP/FP 12 month contract. University health service. Outpatient clinic. No OB or surgery. Fringes include hospitalization, paid vacation, retirement, etc., approximately 11,000 students - city of 23,000. Competitive negotiable income. EOE/AA employer. Contact: C. E. Hughes, M.D., Dir, BEU Health Center, Western IL Univ. Macomb 61455 (309-833-2734) (2)

*(Continued on page 36)*

## Viewbox

(Continued from page 10)

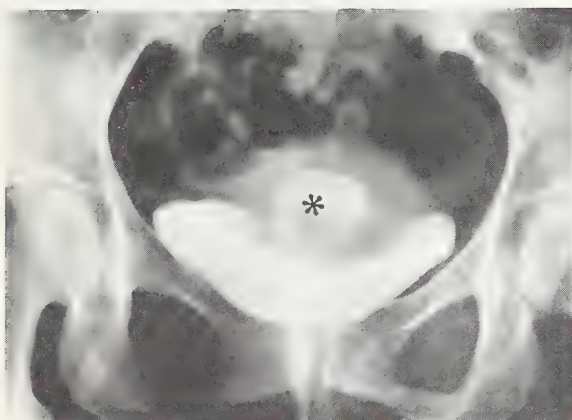


Figure 2

Intravenous urogram with vagina (asterisk) opacified

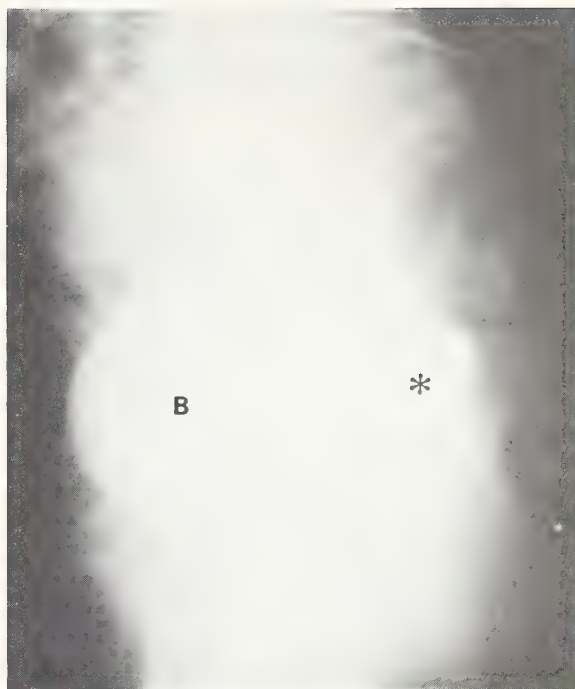


Figure 3

Cystogram with contrast material filling vagina (asterisk)

### DIAGNOSIS: VESICO-VAGINAL FISTULA

The IVP (Figure 1) reveals filling of the vagina. Figure 2 is taken slightly later during the IVP than Figure 1 and shows the contrast filled vagina (asterisk) to better advantage. A lateral film (Figure 3) shows the vagina (asterisk) just posterior to the bladder (B). These films alone do not eliminate the possibility of a uretero-vaginal fistula.

It is important to realize that a normal woman may get some contrast material in her vagina during micturition and this may simulate a fistula. This is especially true if she is voiding in the supine position. The key to the diagnosis of a fistula is both a copious amount of vaginal contrast material seen outlining the vaginal vault and the presence of that vaginal contrast material throughout the examination (even before urinating).

A vesico-vaginal fistula (VVF) was found in the mummy of Queen Henheut of Egypt. She was a wife of King Menuhotep who resigned circa 2050 B.C.<sup>1</sup> Such fistulae are still a problem today.

The patient usually presents with incontinence

which may be slight or so massive that the patient has no need to void through her urethra. The presence of urine in the vagina may be the cause of other presenting symptoms such as inflammation of the vagina and vulva, itching and/or an unpleasant odor. There may be a delay of weeks or even months in the diagnosis of a VVF and the patient may develop chronic cystitis or even a vesico-vaginal calculus traversing the fistulous tract.<sup>(2,3)</sup> The fistulae are usually painless unless secondary to radiation, in which case pain may be the chief complaint.

The etiologies of vesico-vaginal fistulae are several. They may result from dystocia (with or without forceps) and this is probably the most common cause in less surgically oriented foreign countries. In the United States the most common cause is post-operative; with total abdominal hysterectomy being the most likely precursor. Cancer of the cervix, vagina or bladder can also lead to VVF and radiation therapy for such malignancies increases the probability of fistula formation. Recently, Broholt<sup>4</sup> has shown a 47% reduction in recto-vaginal and vesico-vaginal fis-



tulae when alkoxyglycerols are given prior to radiation therapy in patients with carcinoma of the uterine cervix. Finally, less common causes of VVF include complications of a pelvic fracture,<sup>5</sup> traumatic insertion of a foreign body in the vagina, use of a vacuum extractor,<sup>6</sup> following vigorous sexual intercourse<sup>7</sup> and congenital anomaly.

Diagnosis of VVF may be established during a cystogram or IVP. Another method of diagnosis is to fill the bladder with a solution containing methylene blue dye and check for staining of a tampon. Vaginography<sup>8</sup> is, in my experience, the best single method used to evaluate a patient for VVF. Not only is it likely to verify the existence of a fistula that other methods may have missed<sup>9</sup> but it may anatomically localize the exact site of the tract. Also, vaginography evaluates for the presence of additional vaginal fistulae (e.g., recto-vaginal fistulae) that would not be seen during cystogram, cystoscopy or methylene blue studies.

A small VVF of benign etiology may close spontaneously. However, most VVF require some form of surgical intervention. The repair is usually successful if the fistula is of benign etiology. However, fistulae resulting from carcinoma and/or radiation treatment may not be curable.

There are many surgical techniques used today for VVF closure. All these procedures represent an improvement of an eighteen century treatment which was "the waring of a pulverized toad in a little bag over the pit of the stomach."<sup>10</sup>

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## Physician Recruitment

(Continued from page 34)

**MARSHALL:** Population 4,000. County seat of Clark County. Rural community. Comparatively new medical center with available space for 4 doctors. Presently have 2 doctors. Facility fully equipped with lab, x-ray, therapy, emergency room, pharmacy. Located 17 miles from three major hospitals. Have excellent school system and recreational facilities. CONTACT: Donald B. Smitley, Admin., 410 N. 2nd St., P.O. Box 219, Marshall 62441, 217-826-2358. (4)

**ROUND LAKE:** Wanted - general practitioner to take over a forty-five year old practice with great potential. Lovely community, good fishing, golf and schools. CONTACT: G. A. Goshgarian, M.D. 319 Cedar Lake Rd., Round Lake, 60073 (312-546-9455). (1)

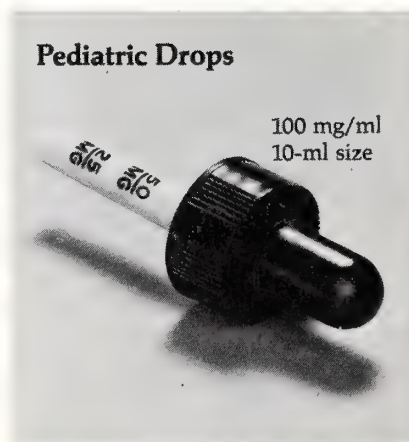
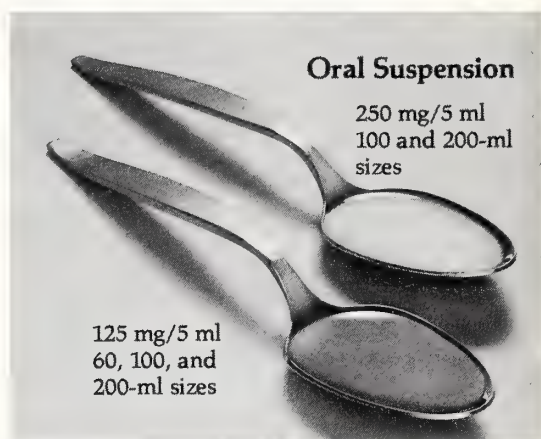
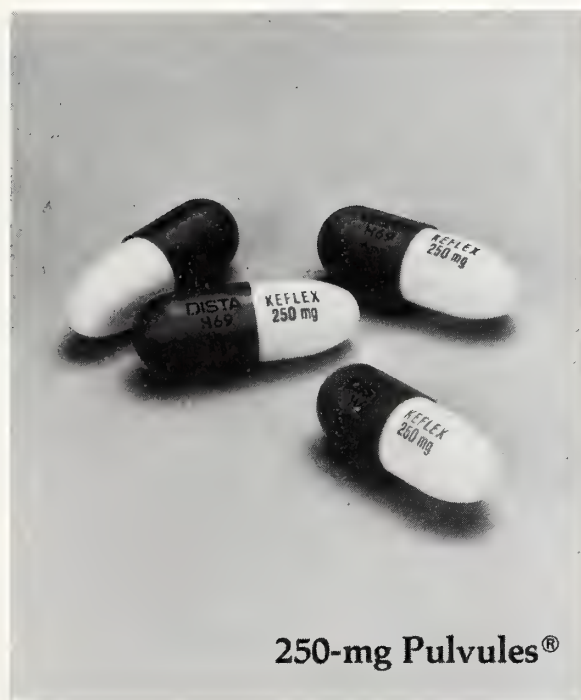
**SALEM:** Population 7,813 need Family Physician, OB, Ped., and General Surgeon. Financial assistance available. Near Kaskaskia Community College and SIU. Boating, Fishing, Hunting, in nearby recreational facilities. 72 miles to major metropolitan area. CONTACT: Harvey H. Acton, Administrator, P.O. Box 608, Salem 62881 (618-548-3194). (1)

**STERLING:** Progressive 16 physician multispecialty clinic seeks physicians in the following specialties: otolaryngology, general surgery, urology, and OB-GYN. Contact: David Bennett, Clinic Manager, Sterling Rock Falls Clinic, Ltd., 101 E. Miller Road, Sterling, 61081 (815-625-4790) (2)

**SULLIVAN:** Population 5,000. New medical center with complete office and ancillary services available. Near universities and colleges. All recreational facilities nearby. CONTACT: Sandra Elder, 2 W. Adams, Sullivan 61951 (217) 728-8316 or (217) 728-4186. (4)

**WATSEKA:** Population service area 35,000. Opening for orthopedic surgeon. 23 physicians on staff at present. 85 miles from Chicago in rural area, 160 bed hospital. Within one hour drive of major universities. Very liberal financial package available first year. Contact Paul F. Wenz, 200 Fairman Street, Watseka 60970. (815) 432-5201. (4)

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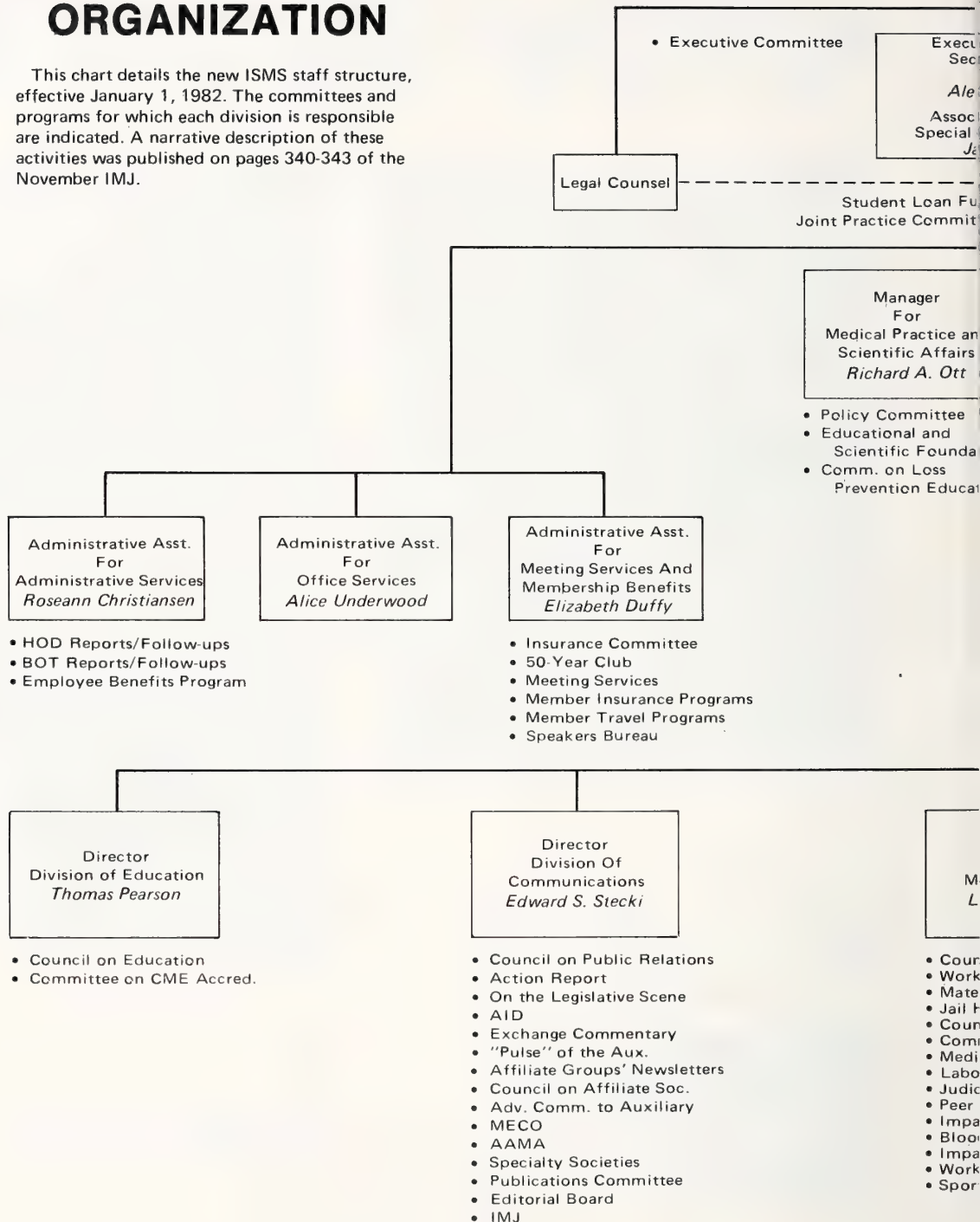


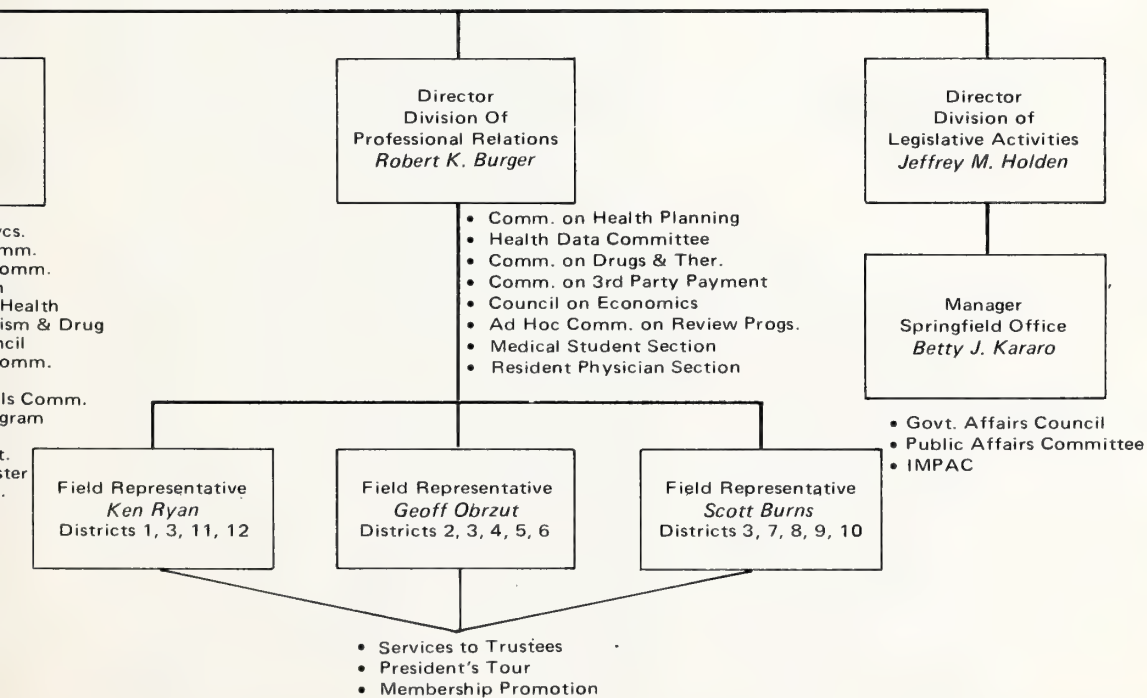
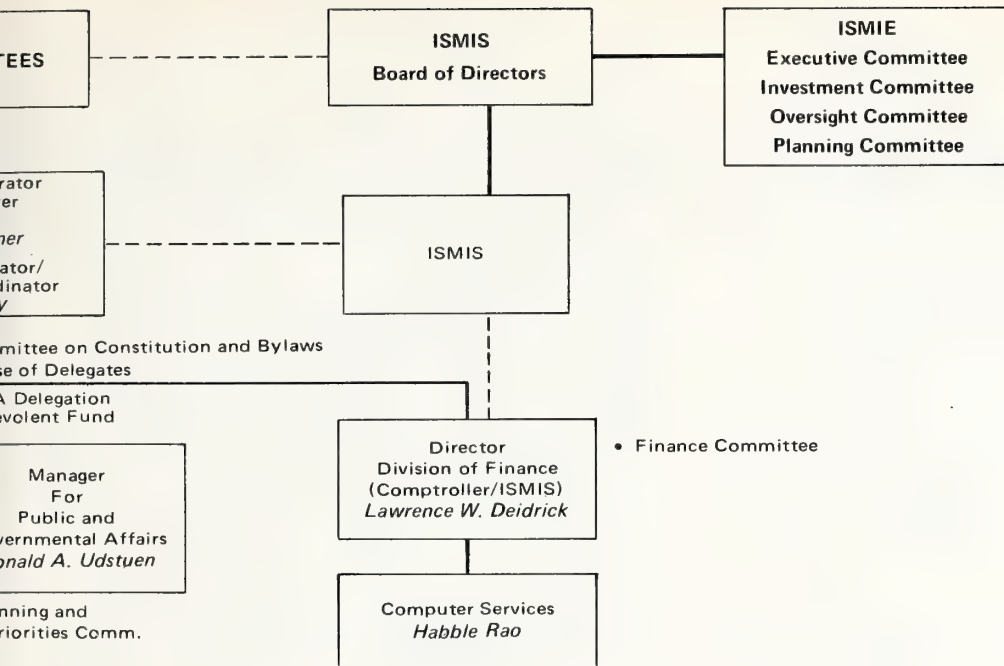
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# ISMS STAFF ORGANIZATION

This chart details the new ISMS staff structure, effective January 1, 1982. The committees and programs for which each division is responsible are indicated. A narrative description of these activities was published on pages 340-343 of the November IMJ.







# ISMS Legislative Update

The Illinois General Assembly completed its Fall veto session on October 29 by restoring some appropriations cut by Governor Thompson, but generally heeded the chief executive's warning of the State's sensitive fiscal condition. In the face of a deepening recession and federal aid cutbacks, record budget shortfalls and depleted treasury reserves that would not meet original budget commitments were predicted. Governor Thompson has indicated that a special session of the legislature prior to the March 16 primary election may be necessary if revenues do not exceed current projections. A special session would almost certainly include cuts in the Illinois Department of Public Aid budget and other health related areas.

While legislators spent much of their time last year struggling to make ends meet and wrestling with legislative redistricting, they did manage to pass (and just as importantly, defeat) legislation of prime importance to ISMS. Two bills intended to improve the malpractice climate in Illinois were passed by the legislature and signed by the governor. House Bill 1029, introduced by Representative Lee Daniels (R-Elmhurst) and sponsored in the Senate by President Philip Rock (D-Oak Park) and Roger Keats (R-Kenilworth) refines interpretation of the legal doctrine of *res ipsa loquitur* (meaning the facts speak for themselves). In order to sue on a *res ipsa* basis, the prosecution must now show that the untoward event would not have occurred absent negligence on the part of the defendant. This legislation was introduced at the request of ISMS in the wake of a Supreme Court minority opinion that may have led to increasing use *res ipsa* in malpractice suits.

Representative Daniels also introduced HB 1365 in response to a judicial opinion that weakened guarantees protecting discussions and minutes of hospital peer review committees. As enacted, HB1365 defines committee records as "privileged" - a legal term which should provide increased confidentiality protections.

The malpractice situation has improved significantly and ISMS is determined to seek further improvements through passage of HB1155. Currently tabled in the Senate Judiciary I Committee, HB1155 would facilitate countersuits by physicians who have been sued unjustly for malpractice. In facilitating countersuits, HB1155 could also serve as a strong deterrent to frivolous lawsuits and ease rising malpractice costs. An attempt to revive this legislation will be made next Spring when the legislature reconvenes. A successful result to this attempt will largely depend on phy-

sician involvement at the local level. All physicians are urged to make use of every available opportunity to let state legislators, especially Senators, know that you support the ISMS counterclaims proposal.

Legislation that would have allowed optometrists to administer diagnostic drugs was defeated in the House Registration and Regulation Committee after passing the Senate. The passage of SB702 was vigorously opposed by many ISMS and Illinois Association of Ophthalmology Key Men. Continued personal lobbying efforts are imperative to counteract a major effort by optometrists to have the bill considered again next spring.

Senate Bill 242, calling for mandatory inclusion of chiropractic insurance benefits in all Blue Cross/Blue Shield policies, passed the Senate last spring. That bill was not called for a vote in the House after it became apparent to chiropractic supporters that they did not have the votes for passage. ISMS Key Men again played a prominent role in the defeat of this legislation, by gaining commitments to oppose the bill from members of the House.

Legislation allowing modification of prescription forms to simplify the process of drug product substitution (DPS), was signed recently by Governor Thompson. The law—SB 211—requires the physician to sign the form in his own handwriting to authorize issuance of the prescription. Newly-printed prescription forms will only be required to have a single signature line along with two boxes accompanied by the printed words, "MAY SUBSTITUTE" or "MAY NOT SUBSTITUTE." The new law does not specify order or location of these choices.

The physician is required to place a mark beside the "MAY SUBSTITUTE" or "MAY NOT SUBSTITUTE" alternative. Failure to place a mark beside the "MAY NOT SUBSTITUTE" alternative will authorize generic interchange. Furthermore, the new statutory language prohibits preprinted or rubber-stamped marks beside either selection.

Current prescription forms are adequate and legal until the physician's supply is exhausted, as long as the physician conforms to the original provision requiring a signature on the chosen line and checking the correct box.

The new law—to which ISMS offered key amendments—was developed by the Illinois Department of Public Health to eliminate much of the confusion resulting from a 1977 law designed to encourage drug substitution.

## PUBLIC AID BILLS

Governor Thompson amendatorily vetoed HB811, intended to implement Illinois Department of Public Aid rollbacks approved last spring. The amendatory veto was in part the product of lengthy negotiations with the Illinois Hospital Association. Major provisions in the legislation include:

- A. Co-payment for all who receive assistance from IDPA (includes General Assistance and Aid to the Medically Indigent). This provision has already been implemented for a number of provider groups, but not physicians or emergency room services. Further application of co-payment is subject to receipt of waivers from the U.S. Department of Health and Human Services.
- B. Elimination of "reasonable cost" as the baseline for hospital reimbursement. This is also subject to an HHS waiver.
- C. Specifics for saving \$106 million in hospital reimbursements through a 14% reduction of inpatient stay days and support for increased utilization of outpatient services.

This also includes an 8% limit on increased hospital *per diem* over previous year's costs. If HHS refuses to grant a waiver to implement this method, the Department may realize savings through creation of a formula providing reimbursement caps based upon multiplying inpatient rates. Again, this formula is subject to HHS approval.

- D. Should HHS refuse to issue a waiver for A, B, or C, then IDPA may develop additional alternatives, with HHS approval, to save the \$106 million.

One area of the Public Aid budget which increased was the line item for physician services. ISMS was successful in negotiating fee increases for basic office visits and obstetrical care and fought off attempts to reduce the \$19 million increase. The fiscal 1982 budget of \$135 million represents a 16% increase over last year.

Listed on succeeding pages are the bills of primary interest to Illinois physicians. Physicians desiring further information on any legislative matter should contact the ISMS Division of Legislative Activities in the Chicago Office. ◀

Bill #	SYNOPSIS WITH ISMS POSITION UNDERLINED	STATUS
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## ABORTION

HB 65	Davis/Thomas-Amends Criminal Code; includes fetus in third trimester as capable of being murdered. <u>ISMS amendment added. No opposition.</u>	Re-committed to Senate Judiciary II Com.
SB 192	Thomas/Davis-Amends Criminal Code; Creates the offense of feticide, or causing the death of a fetus capable of sustained life outside the womb with or without life support. <u>No opposition.</u>	Signed by the Governor.
SB 915	Jeremiah Joyce/Dick Kelly-Amends Criminal Code; defines unborn child as any living member of the human species from fertilization until live birth. Creates Class 2 felony of homicide of an unborn child. <u>No position.</u>	Vetoed by the Governor. Sustained by the Senate.
SB 933	J. E. Joyce-Amends Criminal Code and Abortion Act; defines the term "individual" for purposes of the Criminal Code and the Abortion Law. <u>Under study.</u>	In Senate Judiciary II Com.
SB 934	Lemke/Brumer-Provides that no spouse or parent of minor child is liable for expenses incurred by other spouse of minor child in obtaining an abortion. <u>No position.</u>	Signed by the Governor.
SB 935	Lemke/Vinson-Amends Marriage Act; includes as grounds for divorce the procurement of an abortion without first obtaining written consent of husband. <u>No position.</u>	Passed Senate. On House Spring Calendar.



<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
SB 936	Lemke-Prohibits disbursement of state funds to any private or state college or university that utilizes hospital facilities for the performance of abortions. <u>Opposed.</u>	In Senate Executive Com.
SB 937	Lemke-Prohibits disbursement of state funds to any persons, agency, dept. or profit or non-profit organization that teaches, counsels or recommends abortions. <u>Opposed.</u>	In Senate Executive Com.
SB 938	Lemke-Prohibits disbursement of state funds to any person, agency, department or organization that counsels, recommends or offers abortions without providing alternatives. <u>Opposed.</u>	In Senate Executive Com.
SB 939	Lemke/Bradley-Amends various acts to provide that any physician who performs an abortion procedure in a willful and wanton manner upon a woman who is not pregnant shall have his license revoked and be guilty of a Class 2 felony. <u>ISMS amendment added. No opposition.</u>	Signed by the Governor.
SB 940	Lemke/O'Connell-Amends Abortion Law, provides civil damages for attempting to perform an abortion on a woman who is not pregnant. <u>ISMS amendment added. No opposition.</u>	Signed by the Governor.
SB 941	Lemke/Leinenweber-Amends Abortion Act and repeals Abortion Parental Consent Act; no abortion may be performed on a minor without her parents' consent; no state or municipal institution shall permit its facilities to be used for abortions except to save the mother's life. <u>Under study.</u>	Passed Senate. On House Spring Calendar.

## BLOOD

HB 55	Chapman/Marovitz-Extends repealer date of law relating to liability for furnishing human blood, blood derivatives and human organs from 7/1/81 to 7/1/85. <u>Support.</u>	See H.B. 223 which was signed by the Governor.
HB 223	Pullen/Nimrod-Allows the indefinite waiver from liability for the furnishing of human blood, blood derivatives & human organs. <u>Support.</u>	Signed by the Governor.
HB 1581	Chapman-Amends Civil Administrative Code; creates the Illinois Blood Council; provides for Department of Public Health to implement a state plan for development, collection, distribution and management of supplies of human blood. <u>Opposed.</u>	On Study Calendar of House Health and Family Services Com.

## BOARDS & COMMISSIONS

HB 54	Chapman-Amends Ill. Health Finance Authority Act; defers repeal of act from 1/1/82 to 10/1/86. <u>Opposed.</u>	On Study Calendar of House Health & Family Services Com.
HB 116	Vinson/Nimrod-Repeals the Illinois Health Finance Authority Act. <u>No position.</u>	Passed House. In Senate Public Health Com.

<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
HB 205	Vinson-Repeals the Illinois Health Facilities Planning Act. <u>No position.</u>	Tabled.
HB 220	Pullen-Amends Illionois Health Facilities Planning Act; exempts facilities owned or operated by the Department of Veterans' Affairs from compliance with the provisions of the Act. <u>No position.</u>	Tabled.
HB 446	Ronan-Appropriates \$100,000 for fiscal 1982 expenses of Commission on Health Assistance Programs. <u>Support.</u> <u>ISMS introduced legislation to create this Commission.</u>	Tabled.
HB 815	Pullen/Nimrod-Exempts shelter care facilities from provisions of the Health Facilities Planning Act. <u>No Position.</u>	Passed House. Re-committed Senate Public Health Com.
HB 1164	Pullen-Repeals Health Finance Authority Act and abolishes the Health Finance Authority Fund. <u>No position.</u>	On Study Calendar of House Judiciary I Com.
HB 1269	Pullen-Repeals the Illinois Health Facilities Planning Act. <u>No position.</u>	On Study Calendar of House Hlth & Fam. Srv. Com.
HB 1492	Recreates the State Purchased Human Services Review Act. Board to review contracts & grants & certify rates employed by various human services agencies; replaces Governor's Purchased Care Review Board. <u>No position.</u>	Placed on Spring Calendar.
HB 1874	McCormick-Amends Health Facilities Planning Act; requires Board to make finding regarding health care employees' wages, hours & working conditions before issuing a permit. <u>Opposed.</u>	Tabled.
SB 260	Rhoads-Repeals Illinois Health Facilities Planning Act. <u>No position.</u>	Tabled.
SB 303	Rhoads-Amends Public Aid Code and repeals Health Finance Authority Act; abolishes Health Finance Authority & transfers records and personnel to IDPA. <u>No position.</u>	Tabled.
SB 1029	Schaffer/Woodyard-Amends Health Facilities Planning Act; changes definition of health care facility & makes acquisition of major medical equipment by physicians subject to the act. <u>No support per House of Delegates action.</u>	On Study Calendar of House Health & Family Services Com.

## CHILDREN

HB 482	McClain-Amends Abused & Neglected Child Act; makes failure to report child abuse or neglect a Class A misdemeanor. Opposed in current form. <u>Amend to refer doctor to Medical Disciplinary Board for failure to report.</u>	On Study Calendar of House Health & Family Services Com.
HB 608	Daniels-Creates the Child Passenger Restraint Act; provides parents or custodians of children under 5 are responsible for providing & securing them in approved restraint systems in automobiles. <u>Support.</u> <u>Supported by the Illinois Chapter, American Academy of Pediatrics &amp; Chicago Rehab. Institute.</u>	Placed on House Spring Calendar.



<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
HB 1137	Barnes/Schaffer-Amends Communicable Disease Prevention Act; provides compensation for injuries resulting from mandatory immunization for which no other compensation is available; creates Immunization Adverse Reaction Fund. <u>Support. ISMS legislation.</u>	Passed House. In Senate Public Health Com.
HB 1704	Schraeder-Amends School Code; provides that when pupils do not get required immunization & health examination, the IDPH becomes responsible to see that they get them. <u>Opposed.</u>	Tabled.
HB 1765	Schraeder-Amends School Code; makes Dept. of Public Health responsible for required immunizations & health examinations if pupils do not get them; eliminates exclusion from school for non-immunization. <u>Opposed.</u>	Tabled.
HB 1800	Peters-Amends Abused & Neglected Child Reporting Act; changes definition of abused child; permits access to records by doctors & certain agencies. <u>Opposed.</u>	Tabled.

## DRUGS OR PRESCRIPTIONS

HB 1367	Bower/Berman-Amends Food & Drug, & Pharmacy Practice Act; specifies that provisions allowing substitutions of generic drugs apply only to prescription drugs; changes certain requirements making generic drug substitutions permissible. <u>ISMS legislation. Support.</u>	Amendatory Veto by the Governor. Sustained by both Houses.
HB 1490	O'Connell-Provides a pharmacist may substitute a drug of the same generic name as the drug prescribed unless substitution is expressly prohibited. <u>Opposed.</u>	Tabled.
HB 1622	Stanley-Amends Controlled Substances Act; requires prescriptions for diazepam (valium) to be made on forms supplied by Dept. of R. & E. in triplicate. <u>Opposed.</u>	On Study Calendar of House Judiciary II Com.
HB 1862	Watson-Amends Food, Drug & Cosmetic Act; omits requirement that person conducting investigation of new drug in Ill. file certain information with Director of IDPH. <u>No position.</u>	Tabled.
SB 166	Netsch-Requires there be a presumption that on a physician writing a prescription for a controlled substance he is writing that prescription in "good faith". <u>No opposition. Agreed bill with Dangerous Drugs Commission.</u>	Signed by the Governor.
SB 211	Netsch-Amends Food, Drug & Cosmetic Act & Pharmacy Practice Act; changes nomenclature & procedure of generic drug substitution; ends the use of preprinted "may substitute" prescription forms; requires physician to write on form in own handwriting to prevent generic substitution. <u>Support with ISMS amendment.</u>	Signed by the Governor.
SB 1132	Nimrod-Omits requirement that persons conducting investigations involving new drugs limited to investigational use in humans or animals file certain information with Public Health. <u>No position.</u>	Signed by the Governor.

<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
SB 1205	Totten-Amends Laetrile Act; deletes requirements that IDPH review reports & keep records of the use of the drug. <u>No opposition.</u>	Signed by the Governor.
SB 1206	Totten-Repeals the DES act, dealing with health & insurance of persons exposed to DES. <u>Support.</u>	Signed by the Governor.

## EMERGENCY MEDICAL SERVICES

HB 1586	Braun-Amends Emergency Medical Services Systems Act; prohibits the IDPH from charging fees to local governments for providing standards, licensing & annual inspections for ambulances; increases paramedic use in certain cases; deletes language exempting local government ambulances from standards. <u>Support.</u>	On House Spring Calendar.
HB 1789	Braun/Newhouse-Amends Emergency Medical Svcs. Systems Act; provides for temporary certification of EMT's by the Illinois Department of Public Health. <u>Support.</u>	Signed by the Governor.
SB 401	Davidson/Reilly-Regulates medical transport vehicles through vehicle registrations, proof of financial responsibility, safety tests. <u>Support.</u>	Signed by the Governor.
SB 451	Schaffer-Amends Emergency Medical Services System act; deletes the exemption of ambulances from the licensing and inspections requirement; locally licensed and inspected ambulances exempt from state licensing if local standards have been state approved. <u>Support.</u>	Re-committed to Senate Public Health Com.

## ENVIRONMENTAL HEALTH

HB 1556	McPike-Creates the Employees' Right to Know Act; provides for employer disclosure of information concerning toxic substances & infectious agents. <u>Opposed.</u>	On Study Calendar of House Labor Com.
SB 832	Marovitz-Requires employers to post in workplace a list of all carcinogenic substances used in manufacturing & to furnish list to his employees; provides for training programs on such substances; defines carcinogenic substances. Under <u>study.</u>	Re-committed to Senate Labor Com.

## ETHICS

HB 854	Reilly-Amends Governmental Ethics Act; exempts health care employees from requirement of filing written statement of economic interests. <u>Support.</u>	Tabled.
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## INSURANCE

HB 128	McGrew-Amends State Employees Group Insurance Act; includes dental & optometric care in the group health insurance plan for state employees. <u>No position.</u>	Failed in the House.
HB 332	Bradley-Provides for compulsory no-fault auto insurance; provides for payment of medical services. <u>Opposed.</u>	On Study Calendar of House Insurance Com.



<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
HB 955	Vinson-Amends Insurance Code, Public Aid Code & certain other acts; requires that reimbursement agreements between hospitals and third-party payers be based on prospectively negotiated schedules of rates, not on actual costs to hospital; allows establishment of rate bureaus for negotiations. <u>No position.</u>	On Study Calendar of House Health & Family Services Com.
HB 1142	Stearney-Amends Non-Profit Health Care Service Plan Act; mandates inclusion of chiropractic payments under Blue Cross/Blue Shield. <u>Opposed.</u>	Tabled.
HB 1233	Birkinbine-Amends certain acts relating to health care service & health insurance; removes the power of the Dept. of Ins. to require specific provisions in health service insurance contracts; declares a state policy of not mandating a choice of providers in such contracts. <u>Opposed per House of Delegates action.</u>	Tabled.
HB 1307	Levin-Amends Non-Profit Health Care Service Plan Act; requires a health care service corporation to notify each of its subscribers whenever it intends to increase its rates. <u>No position.</u>	On Study Calendar of House Insurance Com.
HB 1308	Levin-Amends Non-Profit Health Care Service Plan Act; requires a review of time and service standards and claims procedures. <u>No position.</u>	On Study Calendar of House Insurance Com.
HB 1315	Bianco-Amends Insurance Code, other acts; requires insurance contracts and other contracts providing benefits for medical services to provide reimbursement for services legally performed by podiatrists on the same basis as that provided for services of other physicians. <u>Opposed.</u>	Tabled.
HB 1428	Deuster-Amends Income Tax Act; provides a deduction for all amounts paid for hospital and medical insurance premiums. <u>Support.</u>	Tabled.
HB 1483	Levin/Marovitz-Amends Non-Profit Health Care Service Plan Act; provides that if a service plan contract offers two types of individual coverage, beneficiary must be informed of cost & provisions of both. <u>No position - monitor amendments.</u>	In Senate Public Health Com.
HB 1493	Giglio-Amends Ins. Code, Non-Profit Health Care Serv. Plan act, Medical Service Plan Act, & Voluntary Health Services Plans Act; prohibits insurance companies & service plan corporations from making an independent determination that a claim under an accident & health insurance policy of service plan contract is medically unnecessary. <u>No opposition.</u>	Tabled.
HB 1526	Stearney-Requires health insurance policies to provide for payments to chiropractors for services rendered. <u>Opposed.</u>	Tabled.

<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
HB 1822	Epton-Amends Ins. Code; makes technical changes relating to the Illinois Life & Health Insurance Guaranty Assn. Law; amends scope to include contracts to furnish health care services & subscription certificates for medical services. <u>No position.</u>	Tabled.
SB 71	Lemke-Amends the Non-Profit Health Care Serv. Plan, the Medical Service Plan, the Voluntary Health Services Plan Acts and the Illinois Insurance Code; provides that all claims payable under policies of accident & health insurance shall be paid within 30 days after receipt by the insurer of due proof of loss. <u>No opposition.</u>	In Senate Insurance Com.
SB 242	Carroll-Amends the Non-Profit Health Care Service Plan Act; allows the choice of drugless practitioners (chiropractors). <u>Opposed.</u>	Tabled.
SB 928	Berman/Stuffle-Amends Pension Code; amends definitions of group health insurance and insurance company to include coverage of non-profit health care service plans. <u>No position.</u>	Signed by the Governor.
SB 971	Collins-Creates the Prepaid Health Care Act; requires Director of Insurance to establish a prepaid health care plan supplied through private carriers and financed by employee contributions & state funds. <u>Opposed.</u>	In Senate Insurance Com.
SB 1024	Davidson-Authorizes Director of Personnel, with consent of State Employees Group Insurance Advisory Commission, to adopt a self-insurance health plan for state employees. <u>No position.</u>	In Senate Insurance Com.
<b>JURY DUTY</b>		
HB 150	Cullerton/D'Arco-Eliminates exemption for physicians & others from jury service. Provides that jury commissioners or county boards may promulgate rules to provide for exemptions. <u>Opposed.</u>	Tabled.
<b>LICENSING</b>		
HB 724	Mautino-Amends Nursing Act; provides for licensing & regulation of nurse-midwifery. <u>Opposed.</u>	Tabled.
HB 1069	Garmisa-Creates an act providing for regulation of Orthotists & Prosthetists by Dept. of R. & E.; establishes examining board; defines powers. <u>Opposed.</u>	On Study Calendar of House Registration & Regulation Com.
HB 1191	Hallstrom-Amends Physical Therapy Registration Act; requires licensing; redefines physical therapy and physical therapist; defines additional terms; eliminates citizenship requirement for license. <u>No opposition as amended.</u>	On House Spring Calendar.
SB 351	Lemke-Creates Counselor Registration & Licensure Act; provides for standards, criteria and licensing board; provides exemptions. <u>Opposed.</u>	In Senate Insurance Com.



<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
SB 384	Nimrod/Bianco-Amends Podiatry Act; provides for temporary certificates for graduate school trainees. <u>Support.</u>	Vetoed by the Governor. Overridden in Senate. Sustained in House. Total veto stands.
SB 437	Lemke-Amends Medical Practice Act; requires any person licensed to practice any medicine to pass written exam administered by R. & E. every 15 years as condition for license renewal. <u>Opposed.</u>	In Senate Public Health Com.
SB 576	Degnan/Bullock-Amends Medical Practice Act and Veterinary Med. Act; provides that Dept. of R. & E. may require an applicant for license under those acts to submit endorsement from two or three presently licensed individuals. <u>No position.</u>	Signed by the Governor.
SB 631	Becker/Polk-Amends Hospital Licensing Act; provides that Board shall contain 12 members rather than 11; additional member shall be licensed podiatrist appointed by the Governor. <u>No position.</u>	Signed by the Governor.
SB 690	D'Arco-Creates the Illinois Occupational Therapy Practice Act; provides for licensing therapists and assistants. <u>Opposed.</u>	In Senate Insurance Com.
SB 924	Berman-Amends Nursing Act; permits unlicensed nurses who have met all requirements except passing examination to practice nursing until they have passed exam or until 6 months have passed. <u>No position.</u>	Tabled.
SB 1034	Bloom/Stanley-Amends Acts requiring certification or licensing by Dept. of R. & E. to provide that department shall establish expiration & renewal periods by rule. <u>No position.</u>	Signed by the Governor.
SB 1133	Davidson/Polk-Amends Medical Practice Act; adds requirements for medical practice licensing & for treating human ailments without drugs or surgery; adds certain equivalent standards accreditation between foreign & U. S. medical colleges. <u>ISMS amendment added. No position.</u>	Signed by the Governor.
SB 1148	Dawson/Hallstrom-Regulates orthotists & prosthetists by the Dept. of R. & E.; establishes exam board. <u>ISMS amendment added. No position.</u>	Vetoed by the Governor. Overridden by Senate. Sustained by House. Total veto stands.
SB 1224	Bloom-Amends various Acts relating to the licensing of occupations. Provides changes in the fees charged by the Dept. of R. & E. for registration, renewal & other actions. <u>No position.</u>	In Senate Insurance Com.

## MEDICAL/LEGAL

SB 142	Breslin/Berman-Removes contributory negligence as a bar to recovery in civil actions; provides for consideration of comparative negligence in awarding of damages. <u>Opposed.</u>	Failed in Senate.
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<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
HB 145	Terzich/Marovitz-Creates Code of Civil Procedure; combines into one Act the provisions of the Civil Practice Act & other acts relating to civil procedure. <u>No position.</u>	Signed by the Governor.
HB 237	Ebbesen/Grotberg-Stipulates that no federal regulation would supersede the laws of State of Illinois. <u>No position; serious constitutional question.</u>	In Senate Executive Com.
HB 398	Breslin-Amends act requiring compensation for causing death by willful or wanton act, neglect or default; provides that jury may award punitive damages. <u>No opposition so long as the standard of willful or wanton is maintained.</u>	On Study Calendar of House Judiciary I Com.

## MEDICAL SCHOOLS

HB 1507	Kane/Buzbee-Amends So. Ill. University Act; provides for billing, collection & disbursement of charges for professional services performed by faculty members of the School of Medicine. <u>Support.</u>	Signed by the Governor.
SB 573	Degnan-Amends various acts to remove requirement that Dept. of R. & E. set standards for preliminary education for entrance into professional schools. <u>Opposed.</u>	In Senate Insurance Com.
SB 685	Newhouse/Braun-Amends Health Services Education Grants Act; authorizes grants by the Bd. of Higher Education to health institutions for Ill. resident enrollees from minority, racial & ethnic groups. <u>No position.</u>	Signed by the Governor.
SB 1133	Davidson/Polk-Amends Medical Practice Act; adds requirements for medical practice licensing & for treating human ailments without drugs or surgery; adds certain equivalent standards accreditation between foreign & U.S. medical colleges. <u>ISMS amendment adopted - No position.</u>	Signed by the Governor.

## MENTAL HEALTH

HB 113	Kosinski/Egan-Amends Code of Criminal Procedure & Unified Code of Corrections; requires Corrections & Mental Health Dept. to give notice to certain counties of release of prisoners. <u>Support.</u>	In Senate Judiciary II Com.
HB 182	VanDuyne-Amends Criminal & Corrections Codes; deletes reference to defense of insanity; provides for finding of guilty but mentally ill. <u>Opposed.</u>	Tabled.
HB 268	Cullerton-Amends Mental Health Confidentiality Act; permits disclosure of records & communications in criminal proceedings, as determined by court. <u>Opposed.</u>	Tabled.
HB 1517	Catania-Adds to Criminal Procedure Code; prohibits the court from ordering a witness in a criminal proceeding to undergo a psychiatric or psychological examination. <u>No position.</u>	On Study Calendar of House Judiciary II Com.
SB 44	Geo-Karis-Amends Code of Criminal Procedures; defines "criminally dangerous" persons & specifies judicial & correctional procedures. <u>Opposed in current form.</u>	In Senate Judiciary II Com.



<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
SB 45	Geo-Karis-Amends Criminal & Corrections Codes; requires 30 day advance notice & psychiatric examinations when a defendant intends to assert an insanity defense. <u>Opposed in current form.</u>	In Senate Judiciary II Com.
SB 167	Netsch/Sandquist-Amends Mental Health Confidentiality Act; provides that records of a therapist and communications between a recipient and therapist may be admissible in a criminal proceeding in which a recipient raises the defense of insanity. <u>Support.</u>	Signed by the Governor.
SB 391	Simms-Amends Mental Health Confidentiality Act; permits Health Services Plan Corporations to obtain confidential health records of the insured without his or her parents consent. <u>No opposition.</u>	Tabled.
SB 432	Marovitz/John Dunn-Amends Mental Health Dept. Powers & Duties Act; requires Dept. to bring facilities within federal standards by June 30, 1983; provides for sale of facilities not meeting standards by that date. <u>No position.</u>	On Study Calendar of House Public Institutions Com.
SB 490	Sangmeister/Katz-Amends Criminal Procedure, Uniform Code of Corrections; requires that a judicial hearing be conducted before the Dept. of Mental Health may release a former defendant who was committed after being found unfit to stand trial on a criminal charge. <u>No opposition.</u>	Signed by the Governor.
SB 866	DeAngelis-Amends Code of Criminal Procedure regarding defendants found unfit to stand trial, provides for dangerousness hearing and requires commitment for secure inpatient treatment. <u>Opposed.</u>	In Senate Judiciary II Com.
SB 867	Geo-Karis/Barkhausen-Provides for a guilty but mentally ill verdict; specifies plea, trial and sentencing procedures. <u>No opposition.</u>	Signed by the Governor.
SB 882	Geo-Karis/Macdonald-Amends Mental Health Confidentiality Act; provides that a therapist may disclose a record or communication, without consent, to any agency or institution having valid custody of a mental health patient. <u>No opposition.</u>	Vetoed by the Governor.
SB 883	Geo-Karis/Macdonald-Amends various acts to authorize disclosure of a defendant's medical and mental health records to department or agency which has custody. <u>No opposition.</u>	Signed by the Governor.
SB 898	Geo-Karis/Deuster-Amends Corrections Code; requires medical health or mental health records to be transmitted by clerk of court to department, agency or institution where defendant is committed. <u>No opposition.</u>	Vetoed by the Governor.
SB 910	Geo-Karis/Bower-Amends Mental Health Confidentiality Act; requires director of a mental health facility to report a suspected violation of criminal law or other serious incident occurring in the facility. <u>ISMS amendment added-No opposition.</u>	Signed by the Governor.

<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
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## **NURSING**

HB 108	Ronan/Nedza-Appropriates \$300,000 to State Scholarship Commission for loans to nurses under Baccalaureate Assistance Law for Registered Nurses. <u>No position.</u>	Vetoed by the Governor.
HB 109	Ronan/Nedza-Amends Baccalaureate Assistance Law for Registered Nurses, changes areas by which loans are apportioned from state planning regions to federally defined HSA's. <u>No opposition.</u>	Vetoed by the Governor.
HB 662	Bower-Amends the Illinois Nursing Act to specify that "professional nursing" includes all nursing specialties. <u>Opposed.</u>	On Study Calendar of House Health & Family Services Com.
SB 1013	Nedza-Appropriates \$887,000 to State Scholarship Commission for loans to nurses under Baccalaureate Assistance Law for Registered Nurses. <u>No position.</u>	Tabled.

## **PRISONS**

HB 542	Wolf/Lemke-Amends various Acts relating to prisons & jails. Provides that prisoners confined may be required to reimburse the state, county or municipality which maintains the prisons for the expenses of their confinement. It also extends the medical services provisions for inmates which provide that the state will reimburse counties for services over \$2,500. <u>Support.</u>	Amendatorily Vetoed by the Governor. Sustained by both Houses.
HB 676	Henry/Chew-Amends several acts relating to the disclosure of medical records; permits disclosure of hospital & physician records made in connection with the examination, diagnosis & treatment of prisoners confined or imprisoned in a county jail, without their consent. <u>No position.</u>	Vetoed by the Governor.

## **PROFESSIONAL LIABILITY**

HB 310	Jaffe/Lemke-Amends Limitations Act; clarifies applicability of fraudulent concealment exception to medical malpractice suits. <u>No opposition.</u>	Vetoed by the Governor.
HB 845	Grossi-Amends Interest Act & Judgment Act to provide that interest on judgments begins to accrue at the time the cause of action arose, rather than the date of the judgment. <u>ISMS amendment added - No opposition.</u>	On House Spring Calendar.
HB 851	Cullerton/Marovitz-Amends Act relating to legal representation and indemnification of state employees; requires Attorney General to defend any attorney employed by the State Appellate Defender against whom a civil proceeding for malpractice is commenced in connection with employment occurring after Dec. 3, 1977. <u>No opposition.</u>	Re-committed to Senate Judiciary I Com.
HB 882	Vinson/Marovitz-Amends Act regarding limitations; includes dentists (now only physicians & hospitals) in the 2 year (4 year maximum) limitation during which lawsuits must be brought in actions arising out of patient care. <u>Support.</u>	Signed by the Governor.



<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
HB 1029	Daniels/Keats-Amends Civil Practice Act; requires proof that result from treatment would not have ordinarily occurred in the absence of negligence in order to invoke "res ipsa loquitur" doctrine in medical malpractice actions. <u>ISMS legislation. Support.</u>	Signed by the Governor.
HB 1079	Vinson-Creates Act to provide a remedy for victims of frivolous lawsuits; allows victim to proceed against both the frivolous plaintiff & his counsel; allows punitive damages if frivolous action was willful & wanton; other provisions regarding frivolous actions. <u>Support. ISMS legislation.</u>	Tabled.
HB 1155	Vinson/Egan-Amends Civil Practice act; gives defendants the right to sue for damages incurred in defending a lawsuit. <u>Support. ISMS legislation.</u>	Tabled in Senate Judiciary I Com.
HB 1190	Stanley-Amends Limitations Act; specifies period of limitations for actions against attorneys. <u>Support. ISMS legislation.</u>	On House Spring Calendar.
HB 1255	Zwick-Amends Medical Practice Act; provides for automatic suspension of license for one year when physician is convicted of malpractice for a second time, or when physician reaches out-of-court settlement for second time. <u>Opposed.</u>	On Study Calendar of House Insurance Com.
HB 1317	Daniels-Establishes added principles defining the legal responsibility of sellers of products for injuries and damages arising out of the products; applies prospectively. <u>No position.</u>	On House Spring Calendar.
HB 1365	Daniels/Carroll-Amends Medical Studies Act; includes hospital medical staffs among the data-generating entities whose reports are protected by confidentiality. <u>Support. ISMS legislation.</u>	Signed by the Governor.
HB 1366	Vinson-Amends act relating to judgments; changes interest on judgments from 8% to 1% below prime rate as determined by averaging such rate at the three largest banks in the state. <u>Support.</u>	Tabled.
HB 1551	Stearney-Would provide that expert testimony in any civil case would not be conclusive. <u>Opposed.</u>	On House Spring Calendar.
HB 1865	Stearney-Amends Evidence Act; allows expert witness to give an opinion without disclosing facts underlying that opinion; provides that underlying facts may be required by cross examination. <u>Opposed.</u>	Tabled.
SB 273	Marovitz-Limits the use and effect of expert testimony in professional malpractice cases. <u>Opposed.</u>	Tabled.
SB 358	Lemke/Jaffe-Amends Act in regard to limitations; clarifies the applicability of the fraudulent concealment exception to medical malpractice suits. <u>No opposition.</u>	Signed by the Governor.

<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
SB 526	Egan-Amends Abortion Law; precludes doctors & other medical personnel from liability for failure to perform tests to inform parents of the possible birth of a physically handicapped or disabled child; precludes liability for performing abortions resulting in the birth of a live child. <u>Support.</u>	In Senate Judiciary I Com.
<b>PUBLIC AID</b>		
HB 79	Ryan-Illinois Public Aid Code of 1981; repeals present code & revises law relating to public assistance. <u>No position on bill, support only for section on medical assistance.</u>	On House Spring Calendar.
HB 508	Catania/McLendon-Amends Public Aid Code; directs Dept. of Public Aid to provide balanced representation on all statewide advisory committees and county welfare services committees. <u>No opposition with ISMS' amendment.</u>	Signed by the Governor.
HB 554	Daniels-Amends Attorney General & State's Attorneys' Acts; authorizes attorney general to prosecute for offenses arising out of Medicaid & medical assistance programs and other offenses. <u>Opposed.</u>	On House Spring Calendar.
HB 1119	Preston-Amends Public Aid Code to prevent IDPA from lowering or restricting medical benefits for persons already eligible for Public Aid. <u>No position.</u>	On Study Calendar of House Public Inst. Com.
HB 1181	Catania/Taylor-Amends Public Aid Code; requires Public Aid Dept. to establish a grievance procedure for applicants feeling aggrieved by treatment afforded to them so they may file a complaint with the Dept. <u>No position.</u>	In Senate Public Health Com.
HB 1543	Levin-Provides for the establishment of recipient advisory councils in conjunction with each local office of the Dept. of Public Aid. <u>No position.</u>	On House Spring Calendar.
HB 1832	Watson-Amends Food, Drug & Cosmetic Act; specifies that the rules for inclusion & selection of products in the drug formulary listing shall be promulgated by the Director of IDPH. <u>Opposed.</u>	Tabled.
SB 484	D'Arco/Ronan-Amends Public Aid Code; provides for reimbursing certain clinics taking part in the Medical Assistance Program on Jan. 1, 1981. <u>No position.</u>	On House Spring Calendar.
SB 751	Totten-Amends Medical Assistance article of Public Aid Code; sets up a system requiring persons receiving assistance for medical services to make nominal payments directly to the dispenser of such services. <u>Opposed.</u>	In Senate Public Health Com.
SB 796	McLendon-Amends Public Aid Code; requires the IDPA to assure that no person shall be denied necessary medical care because of poverty. <u>No position.</u>	In Senate Public Health Com.
SB 968	Carroll/Matijevich-Amends Public Aid Code; limits to 10 days per spell of illness the in-patient hospital services for which Dept. of Public Aid may authorize medical assistance payments. <u>Opposed.</u>	Tabled in the House.



<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
SB 999	Thomas/Polk-Relates to fraudulent acquisition of public aid; sets procedures for recovering fraud benefits; sets up special investigation unit. <u>No opposition.</u>	Signed by the Governor.
SB 1040	Keats/Levin-Amends Non-Profit Health Care Service Plan Act; prohibits contract exclusions of payment of hospital or medical coverage to persons eligible under Public Aid Code. <u>No position.</u>	Signed by the Governor.
SB 1053	Nimrod-Requires IDPA to provide only such medical assistance as required by federal law for approved state plans & prohibits providing optional services. <u>No opposition.</u>	In Senate Public Health Com.
SB 1054	Totten-Limits payment of medical assistance to amounts required by federal law for federal reimbursement; limits eligibility. <u>Opposed.</u>	In Senate Public Health Com.
<b>PUBLIC HEALTH</b>		
HB 31	Polk/Thomas-Creates Reye's Syndrome Reporting Act; requires physicians and designated persons having knowledge of such incidents to report information to IDPH; confidentiality of information mandated. <u>Support with ISMS amendment.</u>	Signed by the Governor.
HB 351	Giorgi-Creates Health Expense Limitations Plan Act; provides Public Health Director to make payments on behalf of eligible persons for qualified health expenses exceeding specified limits. <u>Opposed.</u>	On Study Calendar of House Health & Family Services Com.
HB 352	Georgi-Amends Lottery Law & State Finance Act; provides that Lottery Board designate a lottery activity with the net proceeds going to the Public Health Dept. to provide financial assistance for the care of certain persons. See H-351. <u>Opposed.</u>	On Study Calendar of House Registration & Regulation Com.
HB 570	Deuster-Amends Civil Administrative Code; requires Dept. of Public Health to promulgate guidelines for ear piercing. <u>No opposition so long as rules and regulations do not affect the Medical Practice Act.</u>	Tabled.
HB 679	Topinka-Amends Civil Administrative Code; terminates on Jan. 1, 1986, the requirement of offering a PAP smear to all adult female hospital patients. <u>Support - ISMS legislation.</u>	Tabled.
HB 1101	E. G. Steele-Amends Sanitary Inspection Act; requires Public Health Dept. to inspect annually every restaurant not located within a municipality or not inspected annually by local authorities. <u>Support per House of Delegates.</u>	On Study Calendar of House Registration & Regulation Com.
HB 1118	Preston/Marovitz-Requires the reporting of neglect or abuse of nursing home residents to IDPH and the investigation of such reports by the Dept. <u>No position.</u>	Signed by the Governor.
SB 655	Netsch/Jaffe-Amends Marriage Act; removes requirement of including copy of laboratory report with blood test certificate; changes required certification from "free from syphilis" to "free from transmissible syphilis." <u>ISMS legislation - Support.</u>	Signed by the Governor.

<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
SB 818	Schaffer/Hallstrom-Amends Phenylketonuria Act; IDPH to promulgate rules requiring the testing of newborns for hypothyroidism; other provisions. <u>No opposition.</u>	Amendatorily vetoed by the Governor. Sustained by both Houses.
SB 834	Marovitz-Amends Medical Practice Act and act relating to public health; makes a physician subject to disciplinary action by R. & E. for failure to inform a breast cancer patient of alternative treatments by giving her a written summary developed by IDPH. <u>Opposed.</u>	In Senate Public Health Com.
SB 1130	Nimrod/Karpiel-Creates Health Statistics Act; authorizes Public Health Dept., with certain restrictions, to collect health data; provides for confidentiality of data. <u>No opposition.</u>	Signed by the Governor.
SB 1131	Nimrod/Miller-Amends act relating to control of high blood pressure; revises definition of "High Blood Pressure Registry;" changes requirement of computerized system to a system "which may be computerized." <u>No position.</u>	Signed by the Governor.

## **RIGHT TO DIE**

HB 1	Katz-Creates Right to Die Act; gives terminally ill person the right to deny life sustaining procedures. <u>Opposed per HOD policy.</u>	On Study Calendar of House Executive Com.
HB 170	Epton-Creates act relating to right of terminally ill person to refuse medical treatment designed solely to sustain the life processes. <u>Opposed.</u>	Tabled.

## **SENIOR CITIZENS**

HB 837	Oblinger-Creates Adult Abuse Act; prohibits mistreatment, abuse, neglect or exploitation of aged or disabled adults; provides protective services; sets reporting requirements; sets penalties. <u>Oppose penalty section.</u>	On Study Calendar of House Judiciary I Com.
HB 1120	Preston-Amends Rehabilitation Services & Aging Acts; requires the Dept. of Rehab. Services & Dept. on Aging to provide home health services, home nursing services, & other services to prevent the unnecessary institutionalization of blind or disabled persons, & persons 60 years old or older. <u>No opposition.</u>	On House Spring Calendar.

## **3RD PARTY PROVIDERS**

HB 84	Deuster-Requires IDPH to establish demonstration projects in relation to prenatal care clinics in at least 3 Illinois communities to be staffed by one or more registered nurses or LPN or holder of temporary midwife license. Authorizes Dept. of R. & E. to issue temporary midwife license. <u>Opposed.</u>	Tabled.
HB 117	Vinson-Amends Optometric Practice Act; requires referral to a physician of patients with conditions outside the scope of optometric practice. <u>Opposed.</u>	Tabled.
HB 118	Vinson-Amends Optometric Practice act; permits use of diagnostic pharmaceuticals by certified optometrists. <u>Opposed.</u>	Tabled.



<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
HB 119	Vinson-Amends Optometric Practice Act; permits use of diagnostic pharmaceuticals by certified optometrists; requires the referral of certain patients to a physician. <u>Opposed.</u>	Tabled.
HB 171	Deuster-Creates Midwife Practice Act; provides for comprehensive regulation of midwife practice; deletes reference to midwife practice in Medical Practice Act. <u>Opposed.</u>	Tabled.
HB 1031	Topinka-Amends Optometric Practice Act; requires an optometrist, under specified circumstances, to recommend that his patient seek help from a physician. <u>Support. ISMS legislation.</u>	Tabled.
HB 1225	Stanley-Amends Vision Service Plan Act; deletes the requirement that a qualified optometrist meet the eligibility requirements of the Illinois, or American, Optometric Association; authorizes a vision service plan corporation. <u>Support. ISMS legislation.</u>	On Study Calendar of House Health & Family Services Com.
SB 101	Jeremiah Joyce-Amends Hospital Licensing Act; provides that provisions be made in standards established by IDPH for employment of clinical psychologists in management of hospital psychiatric programs. <u>Opposed.</u>	In Senate Public Health Com.
SB 702	Bruce/McPike-Amends Optometric Practice Act; permits use of topical ocular pharmaceutical agents by certified optometrists, and requires the referral of certain patients to a physician; removes certain rules. <u>Opposed.</u>	Tabled in House Registration & Regulation Com.
<b>TRUTH IN TESTING</b>		
HB 549	Jones-Creates the Truth in Occupational Testing Act. Applies to standardized tests re. occupational licensing & certification. Requires a test agency to file with the Dept. of R. & E. a copy of the test and acceptable answers. <u>Opposed.</u>	Tabled.
HB 550	Jones-Creates the Truth in Testing Act. Requires a test agency file with the Bd. of Higher Ed a copy of the administered test and the corresponding acceptable answers. Upon request, a test subject shall be given full access to his own individual test results & scoring data. <u>Opposed.</u>	Tabled.
HB 1597	O'Brien-Creates act relating to standardized testing to be administered by Bd. of Higher Education; requires certain reports & notices to be filed by testing agencies; allows subjects to obtain their test results. <u>Opposed.</u>	On Study Calendar of House Executive Com.
<b>WORKERS' COMPENSATION</b>		
HB 609	J. Kelley-Amends various acts to provide a lien for hospitals, physicians & dentists for services rendered under Workers' Comp. & Occupational Diseases Acts. <u>Support.</u>	On House Spring Calendar.
HB 714	Klemm-Amends Workers' Comp Act; provides standard for determining extent of disability; provides for exams by impartial physicians. <u>No opposition.</u>	On House Spring Calendar.

<i>Bill #</i>	<i>SYNOPSIS WITH ISMS POSITION UNDERLINED</i>	<i>STATUS</i>
HB 1432	Schuneman-Amends Workers' Comp. Act; provides that fees charged for treatment of an injured employee shall not be paid beyond rate for similiar services in the community generally. <u>Opposed.</u>	On Study Calendar of House Labor Com.
SB 200	Keats-Amends Workers' Comp. Act; changes method of computing the compensation rate; provides for adjustment of compensation for pre-existing conditions and disabilities; prescribes a standard for determining the extent of disability; provides for examination by impartial physicians. <u>No opposition.</u>	Tabled.
SB 400	Nimrod-Amends Workers' Comp Act; provides a standard for determining the extent of disability and provides for examinations by impartial physicians. <u>No opposition.</u>	Tabled.

## WRONGFUL DEATH

HB 445	Breslin-Amends Wrongful Death Act; provides right to recover for loss of society of the deceased as well as for pecuniary injuries. <u>Opposed.</u>	On Study Calendar of House Judiciary I Com.
SB 706	Egan-Amends Wrongful Death Act; changes title; provides there shall be no cause of action on behalf of any person based on a claim that, but for an act or omission, a human being once conceived would have been aborted; also denies cause of action based on a claim of that person, that, but for an act or omission, he or she would not have been conceived, or once conceived, would have been aborted. <u>Support.</u>	In Senate Judiciary I Com.

## MISCELLANEOUS

HB 1030	Donovan/Rupp-Increases reimbursement for members of Medical Examining Committee, allows for members from U of I or SIU, allows IDPH to charge reasonable fees for lab services. <u>Support.</u>	Signed by the Governor.
HB 1167	Levin/Marovitz-Amends Non-Profit Health Care Serv. Plan Act. No person shall be denied membership on board of directors; or any office or corporation membership, solely on basis of age. <u>No position - monitor amendments.</u>	In Senate Public Health Com.
SB 52	Berning-Regulates medical experiments on human subjects; defines various terms; establishes liability, sets damages for violations. <u>Opposed in current form.</u>	In Senate Judiciary I Com.
SB 65	Keats/Birkinbine-Amends Medical Practice Act; permits two or more corporations authorized by the Medical Corporation Act to form a partnership and to pool or share fees. <u>No opposition.</u>	Signed by the Governor.
SB 514	Berman/Bower-Amends Illinois Administrative Procedure Act; specifies agencies must hold public hearings on proposed rules when certain persons or units request. <u>Support.</u>	Signed by the Governor.
SB 1023	Rhoads/J.J. Wolf-Makes transfers within fiscal 1981 appropriations for Dept. of R. & E.—Dental & Medical Disciplinary Funds. <u>No position.</u>	Signed by the Governor.



# Doctor's News

**PHYSICIANS IN THE NEWS**—Four present or former ISMS members were recently named to office by the American Association of Senior Physicians. **Alexander M. Buchholz, M.D.**, Hazelcrest, will serve as a director and vice chairman of the executive committee of the AAPS board. **Howard C. Burkhead, M.D.**, Evanston, long an active ISMS leader, was elected vice president of the association, and will continue to serve as chairman of the executive committee of the board. **John A. Mathis, M.D.**, Venice, Florida, will serve as a director and **John Post, M.D.**, Elko, Nevada, will serve as president.

**Mahesh K. Agarwal, M.D.**, Lake Forest, has been named a fellow of the American College of Physicians. Dr. Agarwal is a pulmonary disease specialist affiliated with St. Therese's Hospital in Waukegan . . . **Theodore Grevas, M.D.**, Rock Island, served as chairman of the AMA Reference Committee on Amendments to Constitution and Bylaws at the December AMA Interim Meeting in Las Vegas. . . . **William R. Best, M.D.**, Riverside, has been selected chief of staff for the Hines Veteran Administration Hospital, Maywood. Former chief of staff at UI Hospital and associate dean of UI Medical School, Dr. Best will also serve as associate dean and professor of medicine, Loyola University Stritch School of Medicine.

**CHILD SAFETY RESTRAINTS SUPPORTED**—AMA Executive Vice President James H. Sammons, M.D., has asked that members become aware of the AMA position supporting child safety restraints. The AMA House of Delegates has encouraged that all physicians and health care professionals "consider ways in which they can encourage the protection of children in motor vehicles through the use of appropriate child passenger restraining devices and safety belts . . . and support the efforts of the American Academy of Pediatrics, through its 'First Ride-Safe Ride' program, to motivate and assist physicians and health care professionals and hospitals to inform parents of the importance of protecting children in motor vehicles with appropriate restraining systems." This action is consistent with a similar ISMS policy, adopted by the 1981 Interim Session House of Delegates.

**ANTISMOKING ACTION URGED**—The Illinois Interagency Council on Smoking and Disease has suggested that physicians might wish to refrain from subscribing to magazines which carry advertisements for tobacco. In the past two years, ISMS has also encouraged or supported efforts to (1) discourage physicians and their employees from smoking during patient contacts; (2) ban or restrict smoking in public places and (3) ban cigarette advertising.

**SPRING CRUISE PLANNED**—ISMS announces the NILE RIVER CRUISE ADVENTURE departing Chicago and St. Louis on May 8 and returning on May 21, 1982. The trip will include four days in Cairo, Egypt; four days aboard a Sheraton Cruiser on the Nile River, with all sightseeing included, and the last four days in Jerusalem. Additional information is available by contacting ISMS headquarters office.

**DDC CONFERENCE ANNOUNCED**—The Dangerous Drugs Commission will sponsor a two day conference, March 29-30, 1982, on recent advances in research with therapeutic use of cannabis. The "Conference on the Therapeutic Applications of Cannabinoids," will focus on anti-emetic use, clinical trials, the NCI Group C System, treatment regimens and efficacy and adverse reactions. The meeting will be held at the Pheasant Run resort outside Chicago, and is co-sponsored by the Illinois Cancer Council and the University of Chicago Cancer Research Center. CME credit application has been filed. Further information may be obtained by contacting: Wayne Wiebel, conference coordinator, State of Illinois-DDC, 300 N. State Street, Suite 1500, Chicago IL 60610 (312-822-9860).

# IMPAC

**Illinois State Medical Society  
Political Action Committee**  
55 East Monroe Street  
Chicago, Illinois 60603  
312/782-1963

Dear Colleague:

January is traditionally the month of "new beginnings." New Year's resolutions are made and, at least for the first few days, faithfully kept. Holiday feasts are dutifully dieted away. But by the time February and March roll around, many of us have forgotten all of our good intentions.

This same phenomenon seems to occur each year when doctors begin to pay their IMPAC membership dues. In January, many regularly add their IMPAC contribution to their ISMS membership dues payment. Some don't, promising themselves that they will mail the check in separately. But by March, many have simply forgotten their resolve to join medicine's political arm.

When I attended the Political Education Conference, sponsored by AMPAC last year, I was told that many physicians aren't contributing to PACs because "with Reagan in the White House, the Republicans in control of the Senate and a conservative coalition in the House, we don't have anything to worry about." That is absolute nonsense. First of all, it does not address our needs on the state level and, perhaps most importantly, it personified the image our opponents try to give us -- a profession that has grown fat and lazy.

While we may have made some short term political gains, the fight is a long way from over. I can think of nothing to justify any physician's failure to join IMPAC. If you know of a reason, please tear this column out of the IMJ and write me a brief note describing it.

I'd appreciate hearing from you.

Sincerely yours,

*Paul Mahon M.D.*

P.F. Mahon, M.D.  
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, & 110.5. (Federal Regulations require this notice.) IMPAC reports are filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois, 62704. Voluntary membership contributions support political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC.



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# LIFE AFTER 65... IN THE 1980's

## *More active than ever*

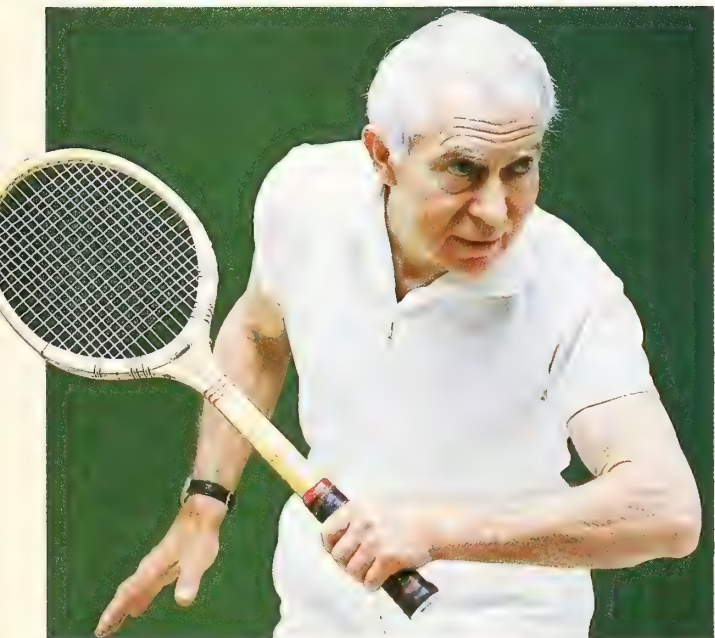
People are not only living longer these days, they're functioning better and leading more productive lives. A growing number of persons eligible for retirement are staying in the work force, some even venturing into second careers.

Those who do retire often choose active hobbies and investigate "late start" educational programs.

## *Medical advances have expanded the physically healthy years*

Significant medical advances, innovative methods of treatment, the development of new medications—these have played important roles in improving the quality of life for the older generation. In addition, there are now many social services available to help the elderly cope with their problems and enrich their lives.





***As with any age group, some cannot cope***

But advancing years do bring increased problems and, frequently, increased anxieties as well. Although many elderly people can cope with these anxieties—and can adapt to the inevitable changes of the later years—there are many who cannot. Their anxiety and psychic tension reach levels that can reduce their coping capacities, perhaps bringing productivity to a halt. Fortunately, the supportive care and empathy of the family physician go far to enhance the emotional well-being of these patients—and to ensure that life after 65 continues as active as before.

For some excessively anxious patients, pharmacological support may be indicated. Because of its special advantages and low-dose effectiveness, Valium (diazepam/Roche) 2 mg is an excellent choice for the elderly patient. Side effects more severe than drowsiness, fatigue and ataxia are rare and seldom serious. As with all CNS-acting agents, patients should be cautioned about drinking alcoholic beverages while on Valium therapy and engaging in potentially hazardous activities such as driving or operating machinery.

*When the emotional problem  
is excessive anxiety*

**VALIUM<sup>®</sup> IV**  
**diazepam/**  
**Roche**  
**2-mg scored tablets**



Please see summary of  
product information on following page.



# VALIUM<sup>®</sup> diazepam/ Roche

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**How Supplied:** For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100\* and 500;\* Prescription Paks of 50, available in trays of 10.\* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

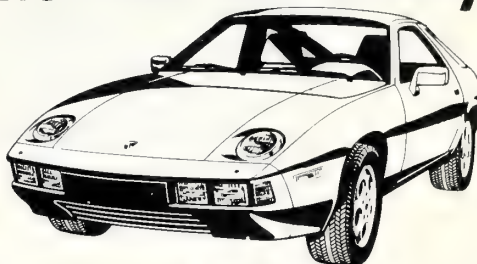
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# Illinois Society, American Association of Medical Assistants

## *Setting Up Practice*

### New Outlook in a New Year for a New Doctor

A physician opening a new practice should have access to medical journals and periodicals, specifically those dealing with his specialty as well as dealing with office management and personnel guidelines.

If a new office is to be opened in this new year by a new physician, thought should be given to the value of AAMA in broadening the network of medical contacts in his new community.

After office space is obtained and the necessary groundwork begun for office setting patient care, the new physician needs to evaluate the type of assistance he will require. If new to the community, the physician should look for his personnel in terms of knowledge of community. Is the medical assistant active in community affairs, school activities, professional organizations? A medical assistant capable of handling office procedures should be able to generate enthusiasm and interest toward her work outside the office setting. A medical assistant who is familiar with personnel of other offices is a great benefit to the busy physician.

If the medical assistant belongs to a professional organization, the assistance she is able to give a new physician is doubled. Why? Because involvement in a professional organization gives a network of acquaintances on whom to draw for information, socialization, education and professional endeavors. An ever broadening network of medical acquaintances is of great importance to the new physician.

If a new physician is asked by a local chapter of the American Association of Medical Assistants to speak at a chapter meeting, he should not

hesitate to take advantage of this opportunity. Members of the American Association of Medical Assistants represent varied specialties through their employers. When speaking before such a group, the new physician is not only educating an interested individual, but he becomes a familiar face and personality to other medical offices.

A new physician should become involved with his local medical society, community activities and organizations involving his office personnel as time permits.

A medical assistant who locks the door of the office at five o'clock and does not give another thought to her employer or her profession is a detriment to a new physician. At a time when a new physician needs to enlarge his network of professional contacts, the medical assistant who thinks her job is "just a job" is missing a very valuable aspect of her chosen field. The best way to ensure a professional attitude is through encouragement that personnel belong to a professional organization. The American Association of Medical Assistants is just such an organization, with membership consisting of medical assistants, nurses, physician's assistants and medical office personnel.

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For further information about A.A.M.A., please contact Mary Lu Ostrowski, CMA, President, Illinois Society, 1704 East Jackson Street, Bloomington, Illinois 61701 or Mari Lakadat, Chairman, Public Relations, c/o William Sawyer, M.D., 107 East Chestnut Street, Bloomington, Illinois.



# Earn up to 20 Category I CME credit hours . . . Attend the 38th Annual Midwest Clinical Conference

The Chicago Medical Society will once again present the only meeting of its kind in the Midwest. This three-day conference will include courses programmed by 27 participating societies which will cover many of the latest discoveries and developments in medical science. Socio-economic courses of vital interest to your practice of medicine have been selected to round out the program.

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College of Surgeons  
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Chicago Heart Association  
Chicago Neurological Society  
Chicago Ophthalmological Society  
Chicago Pathology Society  
Chicago Pediatric Society  
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Chicago Radiological Society  
Chicago Surgical Society  
Chicago Urological Society  
Chicago Society of Industrial Medicine and  
Surgery  
Chicago Society of Internal Medicine  
Chicago Society of Plastic Surgery  
Chicago & Illinois Society of  
Anesthesiologists  
Chicago & Illinois Society of Physical  
Medicine & Rehabilitation  
Cook County Council of Allergy & Clinical  
Immunology  
Illinois Chapter, American College of Chest  
Physicians  
Illinois Chapter, American College of  
Emergency Physicians  
Illinois Chapter, United States Section,  
International College of Surgeons  
Illinois Society of Internal Medicine  
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Section  
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Please send me information and registration materials for  
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# Classified Advertising

All proposed advertisements should be received by the tenth of the month preceding publication. A surcharge of \$2 will be assessed when a box number is requested.

## CLASSIFIED ADVERTISING RATES

	30 words or less	30 to 50 words	50 to 80 words	80 to 100 words
1 insertion	\$6.00	\$9.00	\$14.00	\$20.00
3 insertions	13.00	15.00	28.50	41.50
6 insertions	20.00	26.50	46.00	66.00
12 insertions	33.00	44.00	77.00	110.00

## POSITIONS & PRACTICE OPPORTUNITIES

**MIXED MULTI-SPECIALTY INCORPORATED GROUP**—30 miles south of Chicago seeks Family Practitioner. Life, disability, malpractice insurance and all medical dues paid. X-ray and lab in building. Excellent hospital facilities half block from office. Salary, profit sharing and pension plan \$54,000. Partnership after one year. Write or call collect, Mr. E. Karmis, 1400 Otto Blvd., Chicago Heights, Illinois 60411. Phone (312) 756-4400.

**MULTISPECIALTY GROUP** thirty miles southwest Chicago seeks young family practitioner willing to do Obstetrics and Ob-Gyn man to join expanding practice. Incentive plan, profit sharing, new building. Excellent practice opportunity and schools. Contact Howard Osmus, Administrator, Hedges Clinic, Frankfort, IL 60423. (815-469-2123)

**INTERNISTS**, Board Certified or Eligible, needed for hospital satellite. Excellent opportunity to begin private practice with financial support from hospital. Some teaching responsibilities in accredited internal medicine residency program. Candidates who have recently completed a residency program in internal medicine preferred. Send resume to: Richard A. Emrich, Asst. to Chief Executive Officer, Edgewater Hospital, 5700 N. Ashland Ave., Chicago, Ill. 60660.

**OBSTETRICIAN-GYNECOLOGIST** to join two other Ob-Gyn's in 18 member multi-specialty group. Located in midwest college community of 40,000. Easy access to major metropolitan areas. Community has exceptional recreational and cultural facilities and an excellent school system. Beginning salary \$70,000+ and outstanding fringes. Position available now. Reply Box 1014, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**EMERGENCY MEDICINE POSITION AVAILABLE:** Emergency physician to join professional group practicing in superior emergency department in Aurora, Illinois. Contact Dr. Alan B. Spacone, Emergency Treatment, S.C., at (312) 327-0777.

**SACRIFICIAL PRICE** on rural family practice to replace solo physician leaving for missionary medicine. Well equipped attractive 1300 ft. brick office building includes new 300 m.a. X-ray, Ritter table, Minolta copier, and multitudinous other business and professional utilities, along with thousands of dollars in supplies. About 40 hr. week with excellent gross. Will be selective for the sake of the community we love. \$100,000. M.C. Morris, M.D., P.O. Box 726, Delavan, IL (309) 244-7138.

**ATTENTION:** Internists, Family Practitioners, Pediatricians, OB/GYN. We have excellent opportunities for experienced physicians in Florida, the fastest growing sunbelt state. Prepaid Health Plan with 30,000 members. Sophisticated practice atmosphere, modern facilities and pleasant surroundings. Competitive salary and benefits. Submit Curriculum Vitae to Joan Harris, Manager of Administrative Services, INA Healthplan, 1001 N.W. 62nd Street, Suite 205, Ft. Lauderdale, Florida 33309. (305) 944-4433.

**FAMILY PRACTITIONER**—To locate in Nashville, Illinois. Excellent educational system and recreation. Financially sound community. One hour from St. Louis. JCAH 72-bed hospital in Nashville. Contact: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263, 618 327-8236.

**INTERNIST** needed in Hopedale, Illinois. Hopedale Medical Complex is a highly impressive group of medical facilities. Medical complex management and community physicians are offering strong support, including extraordinary financial security. Please write to: Fred Kopp, Fox Hill Associates, Ltd., 260 Regency Court, Waukesha, WI. 53186 or phone 414/785-6500 collect.

**SUPERIOR EMERGENCY DEPARTMENT** seeking physician to complete group. Excellent pay (best in area), full benefits, 6 weeks paid vacation and CME. \$3000 CME allotment. Brand new 15 room facility to open next spring (ground floor of new 8 floor intensive care pavilion). Call or write (send CV) to Jim Thomas, M.D., Methodist Medical Center, 221 NE Glen Oak Avenue, Peoria, Illinois (309) 672-5000.

**EMERGENCY PHYSICIAN**—join 5 full time physicians with peak load double coverage. Average 28 hours weekly but scheduled such that are off 4 of each 6 weeks. Income and bonuses average \$100,000 plus \$37,000 non-taxable fringe benefits yearly, including \$100,000,000 liability- \$50,000 life- \$2000 monthly disability- \$100,000 accidental death- basic and major medical health and accident insurance programs, Pension and Profit Sharing plans, dues, licenses and up to \$5000 non-taxed, yearly reimbursements all provided by Corporation. Clean, central Illinois town with new Civic Center, private University, much industry and rich farm land. Apply with C.V. to: Box 1026, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.

**EMERGENCY MEDICINE POSITION AVAILABLE**—Full-time emergency physician wanted for moderate volume trauma center. Two hour drive from Chicago. Friendly agricultural community of 12,000. Competitive hourly rates and excellent benefits including malpractice insurance. Call Linda Miller, Emergency Consultants, Inc. collect at (312) 222-9696.

**FAMILY PRACTITIONER**—Immediate practice open in satellite clinic area for board eligible or board certified family practitioner to affiliate with 45 man multi-specialty group in a southeastern suburb of Chicago. First year guarantee of \$55,000 with immediate opportunity to earn more thru incentive plan. Write to Box No. 1029, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago IL 60603.

**WANTED: PHYSICIAN** to share office or take over lease, 344 College Ave, Rockford (SouthWest area), seeing 20-30 patients daily. # 815-964-0500, 11-5 PM.

**FAMILY PRACTICE/EMERGENCY MEDICINE**—Combine the satisfaction of a family practice with the challenge of emergency care. Full time position available in April, 1982, for board eligible/certified FP. Outpatient service only—no OB, surgery, or in-patient responsibilities. Generous compensation with paid malpractice, four weeks vacation and financial incentive. Forward CV or contact H. Stratton, M.D., 2404 E. Washington Road, E. Peoria, Illinois, 61611, (309) 694-6464.

**EMERGENCY MEDICINE:** Physicians sought to staff moderate volume ED in south-central IL. Brand new ED boasts good back-up/support staff and modern equipment. Excellent guaranteed income: flexible scheduling without on-call duty; paid malpractice insurance. For details write or call Dave Schnitzer, 970 Executive Parkway, St. Louis, MO 63141; toll-free 1-800-325-3982.

**GROW WITH US IN THE SUNBELT**—The INA Healthplan needs physicians in family practice and most specialties in Miami, Tampa, Dallas, Phoenix, Tucson, and Los Angeles. Attractive salaries and comprehensive benefits including professional development, retirement, and profit sharing programs are provided. If team interaction and casual living interest you, send a brief CV to Medical Administration, INA Healthplan, Inc., 7616 LBJ Freeway, Suite 303, Dallas, Texas 75251.

**INTERNIST/GENERALIST/FAMILY PRACTITIONER:** Position available in 300 bed active psychiatric rural hospital. Fully JCAH accredited. Three year psychiatric residency program. All treatment modalities. Numerous affiliated educational programs. Near metropolitan and recreational areas. Relaxed, low crime, low turmoil area. Salary Range \$47,902-\$58,282, depending upon qualifications. Good fringe package and possibility of some private practice. Position involves directing a 15 bed medical surgical unit and provide consultation to psychiatric staff. Contact Superintendent, Mental Health Institute, Independence, Iowa 50644. Phone 319-334-2583. Equal Opportunity Employer.

**SPECIALTY PRACTITIONERS**—Good opportunity for psychiatrist, general surgeon, internist with cardiology interest, and orthopedist. Eight family practitioners available for referral. JCAH Accredited 103 bed modern hospital. Up to date staff and equipment. Solid, quiet community-25,000 people in service area. Good schools. Pleasant, safe life style. 40 miles equidistant to Madison or Milwaukee via interstate highway system. Contact Leo Bargielski, Administrator, Watertown Memorial Hospital, Watertown, Wisconsin, 53094-9990.

**OB/GYN SPECIALISTS.** Enjoy the security of group practice with the freedom of independent practice. If you are board certified or board eligible in OB/GYN, we have an interesting opportunity for you. Two specialists are needed immediately to form an independent OB/GYN practice in a very desirable northern Wisconsin community with a drawing population of 70,000. Active practice assured. All

major specialists available for consultation. Business and technical advice will be provided. Outstanding personal benefit programs available. Good income potential. New 35 million dollar hospital. For further information write: Administrator, P.O. Box 1646, Wausau, Wisconsin 54401.

**EMERGENCY MEDICINE:** Medical Director sought for modern, well-equipped ER located in northwestern Illinois. Fee-for-service plus bonus for director's duties; flexible scheduling; paid professional liability insurance. Excellent medical practice in medium-sized, family-oriented community. For complete details call or write Mike Dixon, 970 Executive Parkway, St. Louis, MO 63141; toll-free 1-800-325-3982 (in Missouri call collect 314-878-2280).

**PSYCHIATRIST**—possible openings in correctional/forensic mental health programs. Salary negotiable up to \$325 per day, and fringe benefits. Send resumes to: Mr. Teddie L. Ramsey, A.C.S.W., Chief of Counseling Services, Illinois Department of Corrections, 1301 Concordia Court, Springfield, Illinois 62702.

## SITUATIONS WANTED

**PHYSICIAN** wishes to purchase family practice or OB/GYN practice, or seeks association with either family practitioner or OB/GYN physician. Please reply to box #1017, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**MEDICAL STUDENT**—3rd year, North American, studying medicine in Mexico, seeks guidance and financial support until obtaining U.S. license. In exchange for each year of support she agrees to serve for a year in sponsor organization. Advertiser speaks Spanish, German, Polish, Italian and other related languages. Contact: Illinois Medical Journal Box 1023, 55 E. Monroe, Suite 3510 Chicago, IL 60603.

**GASTROENTEROLOGIST** interested in buying internal medicine practice in an area with potential to practice gastroenterology. Call (502) 895-9006 or write to Box 1024 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**INTERNIST-ENDOCRINOLOGIST**, 32, ABIM, American graduate, university trained, presently in private practice. Seeking practice opportunity with a busy internist or a group of internists. Chicago or suburbs preferred. Will do primary care. Available July 1982. Contact Box 1025, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**INTERNIST** with one year subspecialty cardiology. ABIM qualified, internal medicine residency trained. Passed ECFMG, FLEX. Licensed Illinois, Ohio, Nebraska, New Jersey. Solo, associate, group or hospital based practice desired. Contact Box 1030, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago IL 60603.

**INTERNIST-NEPHROLOGIST**, 34, foreign graduate, presently in training in New Jersey, seeking practice opportunity. Internal medicine or nephrology, solo, group, partnership. Available after July, 1982. Reply to Box 1031, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago IL 60603.

## FOR SALE, LEASE OR RENT

**PROFESSIONAL OFFICE SPACE** for rent in South Elgin, Ill. New building, second floor, with elevator. Four months free rent with 5-year or longer lease. 312/742-8009 or 742-8901.

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**1550 SQ. FT.** office suite in newly constructed professional building in Champaign, Illinois. The building is currently occupied by three separate family dental practices which provide a high volume of patients to the building. The building is in an ideal location in the respect that it is the only professional building that offers medical related services in the area. The single story facility also provides easy accessibility and parking for handicapped and elderly persons, a 50 car parking lot, convenient bus lines, and a health and fitness center for the tenants and their staff. For information, please contact Dr. Thomas Schwalbe at (217) 351-9096.

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## MISCELLANEOUS

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Rapidly expanding mental health center in need of a Medical Director who would be responsible for the administration of medical care and for the medical treatment of all patients of the Center. Specific duties will include organization and performance of the Quality Assurance Program, preventive and consultative services, provision of medical evaluations, scheduling of psychiatric time for case staffing, and 24-hour psychiatric coverage. Excellent opportunity for a dynamic psychiatrist interested in community mental health and seeking a challenge. Applicants must be board certified or eligible in Psychiatry and licensed in the State of Indiana. Must have successfully completed a 3-year residency approved by the American Board of Psychiatry and Neurology. At least 2 years experience in a related field and/or experience working with a multi-disciplinary staff is preferred. Salary range \$60,000-\$75,000 annually. Attractive fringe benefits package. Facilities located 30 minutes from downtown Chicago. Send resume to:

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# Motrin<sup>®</sup> vs aspirin w/codeine...

(ibuprofen)



# compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients.

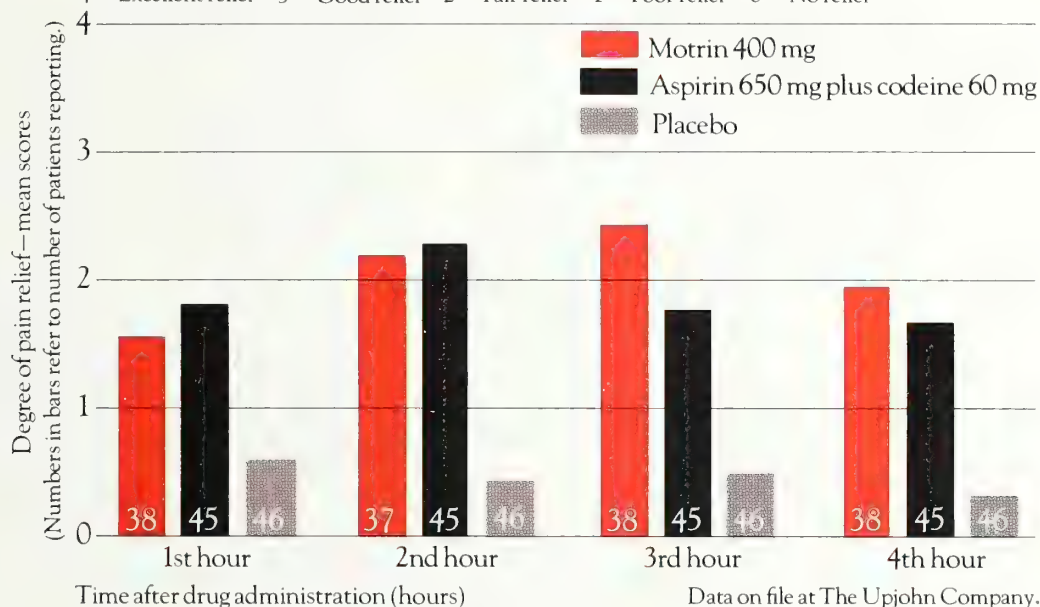
In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ( $p = 0.03$ ) at the three-hour interval.

Active treatment was significantly more effective ( $p < 0.0001$ ) than placebo at all time intervals.

## Comparison of pain relief

### *Motrin* vs aspirin-codeine combination

4 = Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief



One tablet q4-6h prn

For relief of mild to moderate pain:

**Motrin<sup>®</sup> 400mg** TABLETS  
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming • Nonscheduled
- Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

**Upjohn**



# Motrin® (ibuprofen)

## now proved an effective analgesic for mild to moderate pain

**Motrin® Tablets** (ibuprofen, Upjohn)

**Indications and Usage:** Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

**Contraindications:** Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

**Warnings:** Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

**Precautions:** Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

**Drug interactions.** *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

**Pregnancy and nursing mothers:** Motrin should not be taken during pregnancy nor by nursing mothers.

### Adverse Reactions

#### Incidence greater than 1%

**Gastrointestinal:** The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,\* epigastric pain,\* heartburn,\* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,\* headache, nervousness. **Dermatologic:** Rash\* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

\*Incidence 3% to 9%.

#### Incidence less than 1 in 100

**Gastrointestinal:** Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

#### Causal relationship unknown

**Gastrointestinal:** Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

**Overdosage:** In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

**Dosage and Administration:** Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2400 mg per day.

**Caution:** Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

**Upjohn**

THE UPJOHN COMPANY  
Kalamazoo, Michigan 49001 USA

MED B-4-S

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**Blue Cross<sup>®</sup>  
Blue Shield<sup>®</sup>**



# REPORT

## FOR *Illinois Physicians*

---

### **Rockford and Chicago-Based Blue Cross and Blue Shield Plans Are Consolidated**

The Rockford and Chicago-based Blue Cross and Blue Shield Plans are being consolidated into a unified corporation to be called the Illinois Blue Cross and Blue Shield Plan.

The Boards of Trustees of the two corporations agreed to the consolidation during meetings in November and December of last year. Final steps for approval were initiated concerning the various legal, regulatory and corporate requirements which are necessary to complete the consolidation.

(Note: The target effective date for the consolidation was January 1, 1982, pending required approval by regulatory agencies).

"The consolidation represents a big step forward in our efforts to provide the people of Illinois, in particular our members, with the most accessible, cost-effective, quality health care service organization," the officials said in a joint statement.

"The consolidation will broaden the base of both corporations, while minimizing the impact of adverse health care trends, and will reduce the costs of actuarial, underwriting, accounting and systems services," they continued.

"It will also allow us to better meet the competition from commercial insurers," they added.

Officials of both organizations said the Rockford claims office, with about 230 employees, and its service offices around the state with about 20 employees, will continue to operate as usual. The Chicago-based Plan has approximately 2,600 employees in corporate headquarters and another 300 employees in offices around the state, including the state of Illinois claims operation in Springfield.

Officials said "one of the very significant advantages we see in this consolidation is the continued and strengthened local presence exhibited by the corporations. This allows an even more effective response to the diverse needs and desires of all Blue Cross and Blue Shield members in all areas of the state."

Officials explained that "while this consolidation may come as a surprise to many, Plan consolidations are not new to Illinois. When the Blue Cross and Blue Shield movement began in our state in the 1930s, many smaller Plans appeared around the state.

"Gradually, for reasons of efficiency and effectiveness in servicing members, these smaller Plans were eventually consolidated with the Chicago-based Plan, until there were just two Plans in Illinois," they continued.

"With the consolidation of our two Plans, we are better able to provide the best health care protection and services to our subscribers," they added.



# Phone Numbers Change

(Editors Note: In order to clarify some of the misunderstandings regarding the new telephone system installed by the Illinois Blue Cross and Blue Shield Plan in its Chicago headquarters offices, we are repeating this information).

The old "661" exchange has been changed to "938" and all extensions also have been changed, so please make a note of the new telephone numbers.

The Physician Hot-Line number within the (312) area code is 938-7340. The toll free number for area codes other than (312) remain the same, 800-972-8088. Remember, these lines are to be used only by physicians' office personnel and should not be given to patients.

Telephone numbers for the Professional Relations Representatives are:

- Sandra Konnis                      938-7880
- Richard Quigley                  938-7884
- William R. Livingston        938-7060.

The telephone number for the general public is 938-6000.

## Benefit Changes Announced For Illinois Bell Telephone Employees

A number of changes have been made in the Blue Cross and Blue Shield benefit program for Illinois Bell Telephone Co. employees.

The changes, which went into affect January 1, 1982, concern employees in the following Illinois Bell groups—35500, 51100, 53604 and 51165.

The bases for payment vary for specified services. They include 90 percent Usual and Customary for services such as in-hospital medical care, emergency accident and illness; 95 percent U&C for all surgical procedures and 100 percent U&C for services such as lab and x-ray charges.

Other changes include:

- Elimination of the 270-day pregnancy waiting period.
- The availability of chemotherapy benefits for oral, intravenous, subcutaneous intraarterial or intramuscular administration with the following reimbursements:
  1. Hospital inpatient services are paid in full.
  - 2 . Hospital outpatient services for the chemical agent and administration are reimbursed at 100 percent of the Usual and Customary charge when billed by the hospital.
  - 3 . Physicians' office services for the chemical agent is reimbursed at 100 percent of the Usual and Customary charge.
  - 4 . The chemical agent administered in the patient's home is reimbursed 100 percent of the Usual and Customary charge.
- The services of a licensed clinical psychologist are in benefit.
- Pap smears are in benefit with or without a diagnosed condition.
- Additional surgical opinion consultations are in benefit. The benefit includes one consultation by a qualified specialist with whom the Illinois Blue Cross and Blue Shield Plan has an agreement for rendering the service. If requested, the cost of an additional consultation will be paid when the need for surgery is not confirmed by the first arranged consultation.
- Benefits are reduced by the amount of Medicare's payment when applicable for those persons 65 years of age and over.

# Medicaid-Medicare-Champus Report

## MEDICAID

**Crossover Claims Adjudication** — Since implementation of MMIS by IDPA, physicians have had problems understanding the adjudication of deductible and co-insurance amounts due on Medicare/Medicaid combination claims. IDPA's September 23, 1981, notice delineating Medicaid requirements on "Crossover Claims," has caused particular confusion.

IDPA and EDS-Federal policy for submitting crossover claims remains largely unchanged. As in the past, physicians should first submit charges to Medicare using the Medicare claim form, (HCFA 1490) and retain the carbon copy to file with IDPA along with the Explanation of Medical Benefits (EOMB) from EDS-Federal. However, additional information is required *only on copies* of Medicare/Medicaid claims to be processed by IDPA under MMIS. The IDPA recipient number must be included on the HCFA 1490 claim form in the block labeled "Policy or Identification Number." Use of the recipient number and *not* the case number in this block will alert EDS-Federal to generate an EOMB. Additionally, physicians should include their name as it appears on the MMIS Provider Information Sheet in the "Name and Address of Physician or Supplier" space on the HCFA 1490 claim form. Physicians who bill EDS-Federal under a group practice or clinic name must change this field to reflect the name of the treating physicians. The treating physician's name must be included on the service line when several physicians' names are included on the same Medicare claim form. As in all cases, a copy of the Medicare claim form must be submitted to IDPA with a copy of the Medicare EOMB. MMIS provider numbers are to be entered in the lower right-hand corner of the "Provider Name" field of the Medicare claim form.

To designate the address where IDPA reimbursement is to be sent, the MMIS payee codes (1-4) from the Provider Information Sheet should be entered in the "Name and Address of Physician or Supplier" block on the Medicare claim form. Physicians should enter a payee code *only* if other than "01". IDPA will automatically pay all claims to the first payee address unless otherwise instructed.

Once claims are adjudicated by Medicare, they should be forwarded to the Department in the special handling envelope (DPA 2248) or sent to IDPA, P.O. Box 4038, Springfield, Illinois 62708. Crossover claims are *not* to be sent to IDPA at the P.O. Box 4026 address.

**Spend Down Eligibility Requirements** — Individuals applying for Medical Assistance - No Grant (MANG) benefits are currently under a "spend down" program to meet the new IDPA standards for Medicaid eligibility. The Health Care Financing Authority has required that IDPA enforce the "spend down" requirements. These requirements have been in effect for years but the Department had successfully delayed implementation. Federal threats of financial penalties have brought enforcement.

Effective with applications approved on or after September 1, 1981, MANG applicants will *not* receive a medical eligibility card until they have incurred sufficient medical expenses to meet or exceed the "spend down" obligation. In other words, patients are financially responsible for payments to the physician for medical services rendered prior to the eligibility date shown on the IDPA "Green Card."

MANG applicants have received DPA form 2430. This "Summary of Medical Expenses" should be completed by the physician each time service is rendered. *The Summary of Medical Expenses form (DPA 2430) is to remain with the patient. It is not the bookkeeping responsibility of the treating physician.* The Department will utilize this form to determine when the applicant has met his "spend down" obligation and becomes eligible for MANG benefits.

An IDPA program intended to split financial responsibility between the MANG applicant and IDPA may complicate this situation. The Department will pick up a share of the financial obligation of a recipient subject to "spend down" in certain hardship cases. In these cases, IDPA will notify treating physicians that it will be responsible for a given percentage of expenses incurred.

A split transmittal form (DPA 2432) will be completed by the Department to identify: (1) the patient's financial responsibility; and (2) that amount which may be billed to the Department by the treating physician. This split billing form will be sent by IDPA to the physician for services provided on the first day of eligibility for the MANG beneficiary. This will allow him to submit a routine MMIS invoice for the remaining balance due and allowed by the Department. Services incurred prior to the first day of eligibility are to be billed to the patient as private pay. A corresponding split billing transmittal form (DPA 2432) must accompany a completed MMIS invoice when submitted to IDPA. Claims submitted without the DPA 2432 will not be reimbursed.



ISMS strongly suggests that physicians and their office staff monitor IDPA eligibility “Green” cards closely for eligibility dates and case numbers during this MANG “spend down” initiative. *Case numbers with the “9-” prefix code belong to a MANG beneficiary.* Contact with County and State IDPA offices may be necessary for specific inquiries. Chicago Medical Society members may contact Christine Szuflita of CMS staff for normal inquiries about Public Aid. Audit related questions should be directed to the ISMS Division of Professional Relations. Physicians outside of Cook County may continue to direct all inquiries to ISMS.

**MMIS Update** — Many physicians have noticed a significant delay in the Department’s processing of MMIS claims. ISMS has pressed IDPA for a swift response.

The Department has acknowledged claims processing problems which have caused payment delays. Since most physicians did not receive the necessary MMIS billing materials in time for MMIS implementation, claims began arriving late and in huge numbers. As a result, both old (DPA 132) claims and new (MMIS) claims were significantly delayed in processing. When end-of-the-month MMIS physician billings arrived at IDPA during the first weeks of November and December, a major claims processing backlog already existed.

IDPA has since reorganized existing personnel and hired new workers to process physicians’ claims. ISMS will continue to press the Department for improvement.

On another front, IDPA is now considering implementation of a Laboratory Services Volume Purchase Plan (LVPP). The proposal, part of a cost containment initiative, would contract laboratory services for the State’s Medical Assistance Program to one or two facilities. ISMS is now studying the plan’s feasibility pursuant to the Department’s request. The ISMS Board of Trustees will take action on this proposal at its January 23, 1982, meeting.

## MEDICARE

April, 1978, EDS-Federal implemented a Post-Payment Utilization Survey (PPUS) program. This program was to fulfill contract requirements between DHHS and Medicare fiscal intermediaries. Physicians are selected for a PPUS Medicare audit when their procedure charges appear to exceed those of their peers. This type of review is triggered when physicians, billing for same services, test in the top three percent of other physicians of same specialty and geographic area. Audits are performed only by registered nurses. Auditors review approximately fifteen patient records and concentrate review on the following medical data: date of service, diagnosis, symptoms-complaints, documentation of vital signs, procedures performed, prescriptions ordered and the intended follow-up.

In the majority of Post-Payment Utilization Surveys conducted by EDS a financial recoupment will not be indicated. However, if the audit proves that a physician was mistakenly reimbursed for an uncovered procedure, EDS-Federal will seek to recoup that amount from the physician. EDS-Federal will *not* seek to recoup from a patient if monies were paid by EDS for an uncovered service and the treating physician did not accept assignment.

If audit results indicate that a physician overutilized certain services or that the services performed were not medically necessary, the audited physician may appeal the findings to EDS. Audited physicians will also receive a letter clarifying pertinent Medicare policy if the audit did reveal discrepancies.

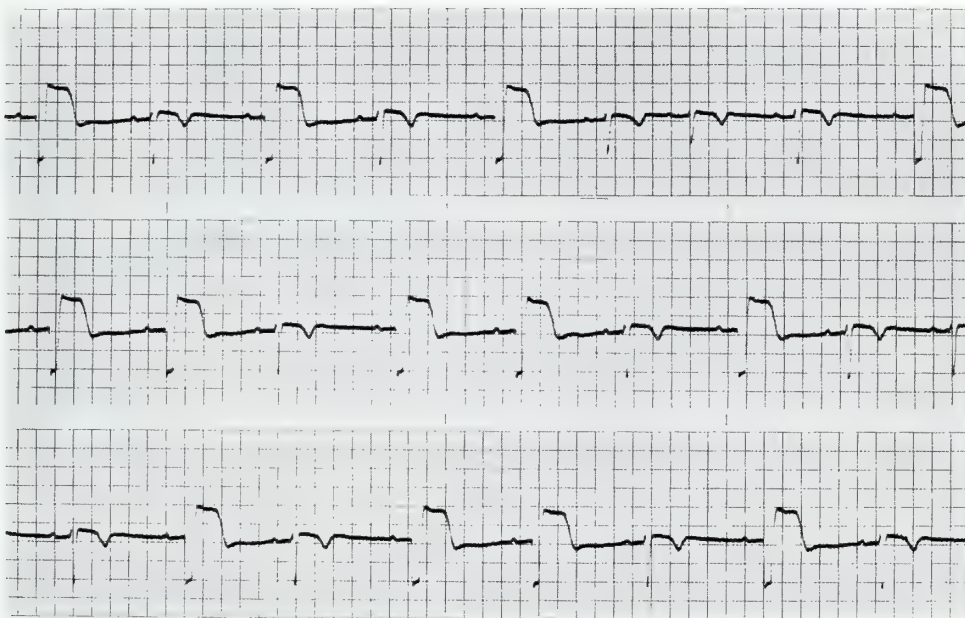
It is important to note that these reviews are not associated with other audits conducted on a physician’s Medicare billing pattern. These Post-Payment Utilization Survey audits are required by DHHS in accordance with Title XVIII and are not generated by patient complaint. ISMS has and will continue to monitor all auditing procedures performed by EDS-Federal on physicians’ Medicare practices. The Society is available to its physician members for any clarification of Medicare policy. Physicians who are notified that they have been selected for a Medicare audit and desire ISMS assistance, should contact the ISMS Division of Professional Relations.

Separately, EDS-Federal recently notified physicians about recent charges for additional services now covered for Medicare-Part B reimbursement. Intraocular Lens (IOLS) and prosthetic devices necessary for home parenteral and enteral systems now will be reimbursed under Medicare-Part B. Physicians and their office staff should be aware of the changes delineated in the November 1981 EDS “Medicare Newsletter.”

# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*The patient is a seventy-two year old woman who presented to the emergency room because of recent onset palpitations. She also complained of some weakness and lightheadedness. Physical examination demonstrated a blood pressure of 110/80mmHg and fine crepitant rales in both lung bases. The examination of the heart showed a grade 3/6 systolic murmur and a point of maximal impulse in the sixth intercostal space, mid-clavicular line. The pulse rate was 150 beats per minute and was irregular with an apical-radial pulse deficit. A twelve lead ECG confirmed the impression of atrial fibrillation and showed complete left bundle branch block. She was admitted to the coronary care unit. Intravenous digoxin was given and she converted to a sinus bradycardia. A continuous rhythm strip is shown.*



## Questions:

### 1. The ECG rhythm strip shows:

- A. Idioventricular escape beats.
- B. Sinus arrhythmia and bradycardia.
- C. First degree atrioventricular block.
- D. Bradycardia dependent bundle branch block.
- E. All of the above.

### 2. The following statement(s) is/are true:

- A. The digoxin should be held.
- B. The digoxin should be continued at a maintenance dose.
- C. Propranolol should be added to maintain adequate atrioventricular block.
- D. This patient could have a phase 3 and a phase 4 bundle branch block.

(Continued on page 90)



**METHYLDOPA?**  
**RESERPINE?**  
**OR**  
**INDERAL<sup>®</sup>**  
(PROPRANOLOL HCl)





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Proper patient selection is always important. **INDERAL** should be used only in the absence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.\*

**INDERAL** permits you to achieve smooth, effective control of blood pressure with few troublesome side effects\*. Moreover, because side effects are usually not dose-related, higher doses can be prescribed with confidence.

**INDERAL**. The choice is clear when it comes to well-tolerated and effective control of hypertension.

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(PROPRANOLOL HCl)

**B.I.D. FOR  
HYPERTENSION**

40 MG AND 80 MG TABLETS

\*Please see following page  
for Brief Summary of  
Prescribing Information.



# THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD

## INDERAL® (PROPRANOLOL HCl) B.I.D. FOR HYPERTENSION

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)  
INDERAL® BRAND OF propranolol hydrochloride A beta-adrenergic blocking agent

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG.

### CONTRAINDICATIONS

INDERAL is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

### WARNINGS

**CARDIAC FAILURE:** Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA:** Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**USE IN PREGNANCY:** The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the recommended human dose.

### PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely served if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Additionally, the pharmacologic activity of INDERAL may produce hypotension and/or bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be served at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

### ADVERSE REACTIONS

**Cardiovascular:** bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura

**Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium and decreased performance on neuropsychometric tests

**Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis

**Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with and sore throat, laryngospasm and respiratory distress

**Respiratory:** bronchospasm

**Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

**Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

### ORAL

#### DOSEAGE AND ADMINISTRATION

**HYPERTENSION—Dosage must be individualized.** The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg/day. In some instances a dosage of 640 mg may be required. The time needed for full tensile response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

#### PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

#### INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

#### OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

**BRADYCARDIA—ADMINISTER ATROPINE** (0.25 to 1.0 mg): IF THERE IS NO RESPONSE TO VAGAL BLOCKADE, ADMINISTER ISOPROTERENOL CAUTIOUSLY **CARDIAC FAILURE—DIGITALIZATION AND DIURETICS.**

**HYPOTENSION—VASOPRESSORS, e.g., LEVATERENOL OR EPINEPHRINE (THE EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).**

**BRONCHOSPASM—ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.**

#### HOW SUPPLIED

**TABLETS** INDERAL (propranolol hydrochloride)

No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

#### INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. pH is adjusted with citric acid. Supplied as: 1 ml ampuls in boxes of 10.

**Ayerst**

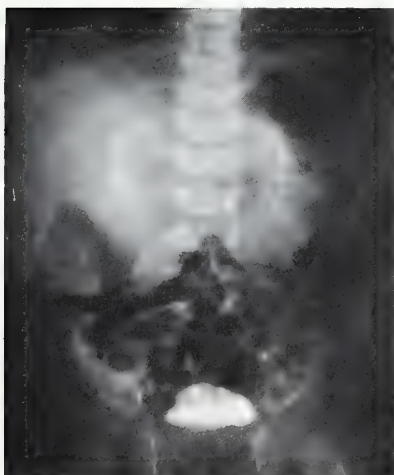
AYERST LABORATORIES  
New York, N.Y. 10017

# The Viewbox

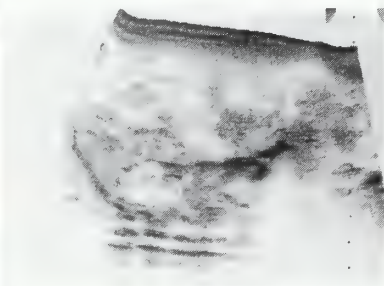
Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This month's Viewbox was contributed by Richard E. Marsan, M.D., associate professor of radiology, Loyola Univ. Med. Center, Maywood.*

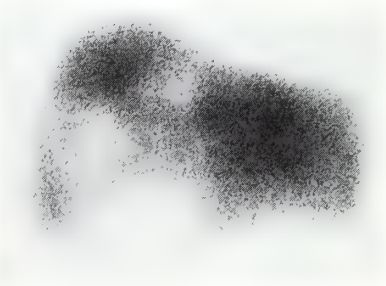
*The patient, a two month old male infant, was brought to a pediatrician because of failure to gain weight. During physical examination a right upper quadrant mass was palpated. No other abnormalities were found. All laboratory studies were within normal limits. Chest X-ray was normal.*



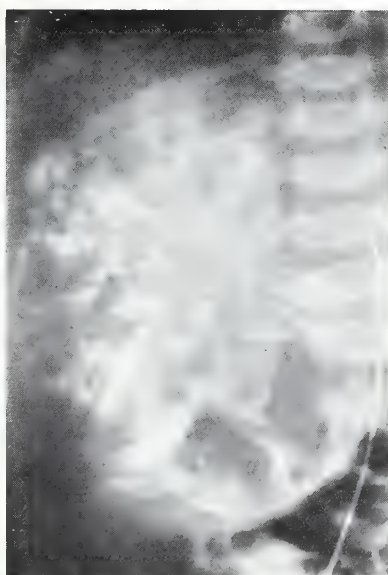
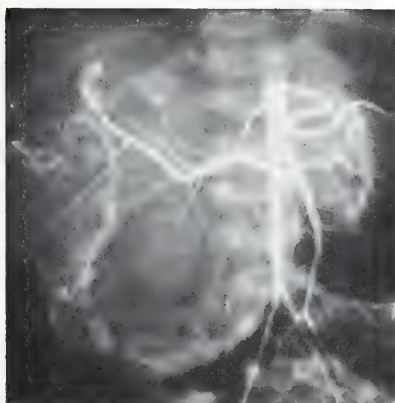
**Figure 1**  
*Excretory urogram*



**Figure 2**  
*Ultrasound—longitudinal section through liver*



**Figure 3**  
*Frontal view of liver-spleen scan*



**Figures 4 and 5**  
*Angiogram—Early and late films*

**The findings are compatible with:**

- (1) neuroblastoma
- (2) hepatoblastoma
- (3) hemangioma
- (4) hepatoma

*(Continued on page 135)*



# MAN MAY NOT LIVE BY A THIAZIDE ALONE





Initial therapy with modest salt restriction and a diuretic alone will control about 40% of all hypertensives.<sup>1</sup> For the other patients with essential hypertension, an additional drug is needed to reduce blood pressure below 90 mm Hg.

With **INDERIDE**, effectiveness is significant and sustained.\* In more than 4 out of 5 patients followed for 6 to 18 months (81.8 to 86.4%), concurrent administration of propranolol and a diuretic maintained blood pressures below 90 mm Hg.<sup>2</sup> Acceptability is well-established.

The two components of **INDERIDE**—propranolol HCl and hydrochlorothiazide—complement each other and may allow lower dosage to help keep side effects to a minimum and encourage long-term compliance as well as control.

# When you know you need more than a thiazide

## **INDERIDE®**

Each tablet contains **INDERAL®**  
(propranolol HCl), 40 mg or 80 mg,  
and hydrochlorothiazide 25 mg

### **B.I.D.**

**AVAILABLE STRENGTHS:**

**40/25**

**80/25**

Please see brief summary of prescribing information on following page.

\*As with all fixed combinations, **INDERIDE** is not indicated for initial therapy of hypertension and should not be used in dosage which would provide more than 100 mg hydrochlorothiazide per day.



BRIEF SUMMARY  
(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

## INDERIDE®

BRAND OF  
propranolol hydrochloride  
(INDERAL®)  
and hydrochlorothiazide

No. 474—Each INDERIDE®.40/25 tablet contains	
Propranolol hydrochloride (INDERAL®)	40 mg
Hydrochlorothiazide	25 mg
No. 476—Each INDERIDE®.80/25 tablet contains	
Propranolol hydrochloride (INDERAL®)	80 mg
Hydrochlorothiazide	25 mg

**WARNING:** This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

**DESCRIPTION:** INDERIDE combines two antihypertensive agents. INDERAL (propranolol hydrochloride), a beta-adrenergic blocking agent, and hydrochlorothiazide, a thiazide diuretic-antihypertensive.

**INDICATION:** INDERIDE is indicated in the management of hypertension. (See boxed warning.)

**CONTRAINDICATIONS:** Propranolol hydrochloride (INDERAL®): Propranolol hydrochloride is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

**Hydrochlorothiazide:** Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

**WARNINGS:** Propranolol hydrochloride (INDERAL®): CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuation of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in re-starting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

**USE IN PREGNANCY:** Propranolol hydrochloride (INDERAL®): The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

**Hydrochlorothiazide:** Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**Nursing Mothers:** Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

**PRECAUTIONS:** Propranolol hydrochloride (INDERAL®): Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

**Hydrochlorothiazide:** Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

**ADVERSE REACTIONS:** Propranolol hydrochloride (INDERAL®): Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**Hydrochlorothiazide:** Gastrointestinal: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reaction.

Other: hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

**DOSEAGE AND ADMINISTRATION:** The dosage must be determined by individual titration (see boxed warning).

Hydrochlorothiazide is usually given at a dose of 50 to 100 mg per day. The initial dose of propranolol is 40 mg twice daily and it may be increased gradually until optimum blood pressure control is achieved. The usual effective dose is 160 to 480 mg per day.

One to two INDERIDE tablets twice daily can be used to administer up to 320 mg of propranolol and 100 mg of hydrochlorothiazide. For doses of propranolol greater than 320 mg, the combination products are not appropriate because their use would lead to an excessive dose of the thiazide component.

When necessary, another antihypertensive agent may be added gradually beginning with 50 percent of the usual recommended starting dose to avoid an excessive fall in blood pressure.

**OVERDOSE OR EXAGGERATED RESPONSE:** The propranolol hydrochloride (INDERAL) component may cause bradycardia, cardiac failure, hypotension, or bronchospasm.

The hydrochlorothiazide component can be expected to cause diuresis. Lethargy of varying degree may appear and may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function, and in the absence of significant serum electrolyte changes or dehydration. The mechanism of central nervous system depression with thiazide overdosage is unknown. Gastrointestinal irritation and hypermotility can occur; temporary elevation of BUN has been reported, and serum electrolyte changes could occur, especially in patients with impairment of renal function.

**TREATMENT:** The following measures should be employed. GENERAL—If ingestion is, or may have been, recent, evacuate gastric contents taking care to prevent pulmonary aspiration. BRADYCARDIA—Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. CARDIAC FAILURE—Digitalization and diuretics. HYPOTENSION—Vasopressors, e.g., levaterenol or epinephrine. BRONCHOSPASM—Administer isoproterenol and aminophylline. STUPOR OR COMA—Administer supportive therapy as clinically warranted. GASTROINTESTINAL EFFECTS—Though usually of short duration, these may require symptomatic treatment. ABNORMALITIES IN BUN AND/OR SERUM ELECTROLYTES—Monitor serum electrolyte levels and renal function; institute supportive measures as required individually to maintain hydration, electrolyte balance, respiration, and cardiovascular-renal function.

**HOW SUPPLIED:** No. 474—Each INDERIDE®.40/25 tablet contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 476—Each INDERIDE®.80/25 tablet contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

**References:** 1. Kaplan, N. M., Beta-blockade in the treatment of mild to moderate hypertension, in Braunwald, E. (ed.) Beta-Adrenergic Blockade, A New Era in Cardiovascular Medicine, Amsterdam, Excerpta Medica, 1978, pp. 253-263. 2. Veterans Administration Cooperative Study Group on Antihypertensive Agents: J.A.M.A. 237:2303 (May 23) 1977.

**Ayerst**

AYERST LABORATORIES  
New York, N. Y. 10017

## Obituaries

**\*Allyn, Paul Richard, M.D.**, Springfield, died November 26, 1981, at the age of 68. Dr. Allyn was a 1939 graduate of the Columbia University College of Physicians and Surgeons, New York City.

**\*Aries, Leon J., M.D.**, Chicago, died December 17, 1981, at the age of 72. Dr. Aries was a 1932 graduate of the University of Illinois College of Medicine.

**\*\*Austin, Margaret Howard, M.D.**, Hinsdale, died November 6, 1981, at the age of 89. A 1923 graduate of Rush Medical College, Dr. Austin was the first female resident at Cook County Hospital.

**\*Bronstein, I. Pat, M.D.**, Chicago, died November 21, 1981, at the age of 80. Dr. Bronstein was a 1926 graduate of Rush Medical College.

**Carlson, H. Clifford, Jr., M.D.**, Richmond, Virginia, died October 7, 1981, at the age of 62. Dr. Carlson, formerly of Rockford, was a former ISMS member.

**Crisp, Joseph, Jr., M.D.**, Hagerstown, Maryland, died September 11, 1981, at the age of 66. Dr. Crisp had formerly practiced in Peoria.

**\*\*Egan, Edward M., M.D.**, Oak Park, died December 17, 1981, at the age of 83. Dr. Egan was a 1922 graduate of the Loyola University Stritch School of Medicine.

**\*Fein, Alfred L., M.D.**, Chicago, died October 15, 1981, at the age of 63. Dr. Fein was a 1943 graduate of the University of Illinois College of Medicine.

**Finegan, Thomas F., M.D.**, Oak Lawn, died December 26, 1981, at the age of 93. Dr. Finegan was a 1910 graduate of the Northwestern University Medical School.

**\*\*Finsky, Morris E., M.D.**, Chicago, died December 20, 1981, at the age of 84. Dr. Finsky was a 1923 graduate of Rush Medical College.

**\*Freda, Vincent C., M.D.**, Chicago, died November 9, 1981, at the age of 75. Dr. Freda was a

1935 graduate of the University of Illinois College of Medicine.

**\*\*Friend, Alex J. G., M.D.**, died November 10, 1981, at the age of 81. Dr. Friend was a 1924 graduate of Medizinische Fakultät der Universität Hamburg in Hamburg, Germany.

**\*Henrikson, Irvin R., M.D.**, Lincoln Park, Michigan, died October 22, 1981, at the age of 44. Dr. Henrikson was a 1963 graduate of the Wayne State University College of Medicine.

**\*\*Hibbert, George F., M.D.**, Skokie, died December 15, 1981, at the age of 85. Dr. Hibbert was a 1921 graduate of Rush Medical College.

**\*Liebman, Samuel, M.D.**, Wilmette, died November 14, 1981, at the age of 68. Dr. Liebman was a 1937 graduate of the University of Illinois College of Medicine.

**\*\*Lindsay, John R., M.D.**, Evanston, died December 21, 1981, at the age of 83. Dr. Lindsay was a 1925 graduate of the McGill University Faculty of Medicine, Montreal, Quebec.

**\*Mauch, Stuart W., M.D.**, Belleville, died October 27, 1981, at the age of 64. Dr. Mauch was a 1943 graduate of the St. Louis University School of Medicine, Missouri.

**\*Pisarik, Helen C. Brezina, M.D.**, Chicago, died November 2, 1981. Dr. Pisarik was a 1932 graduate of the University of Illinois College of Medicine, Chicago.

**\*\*Rambar, Alwin C., M.D.**, Highland Park, died November 8, 1981, at the age of 78. Dr. Rambar was a 1926 graduate of the State University of New York Upstate College of Medicine.

**Rammelkamp, Charles H., Jr., M.D.**, Cleveland Heights, Ohio, died December 5, 1981, at the age of 70. Dr. Rammelkamp was a University of Chicago Medical School graduate.

**\*Schneider, Max, M.D.**, Glencoe, died December, 1981, at the age of 74. Dr. Schneider was a 1935 graduate of Rush Medical College.



**Schlesinger, Lee, M.D.**, Oak Brook, died October 25, 1981 at the age of 76.

**\*\*Shaw, Noel G., M.D.**, Evanston, died December 23, 1981, at the age of 79. Dr. Shaw was a 1929 graduate of Rush Medical College. A past president of the Chicago Medical Society, Dr. Shaw had received a 1981 public service award from CMS for his contributions to the community.

**\*Siedlinski, John E., M.D.**, Evergreen Park, died November 9, 1981, at the age of 75. Dr. Siedlinski was a 1935 graduate of the Chicago Medical School.

**\*\*Supan, Peter C., M.D.**, Effingham, died October 27, 1981, at the age of 85. Dr. Supan was a 1923 graduate of the St. Louis University School of Medicine, Missouri.

**\*\*Vanderkloot, Albert, M.D.**, Chicago, died December, 1981, at the age of 88. Dr. Vanderkloot was a 1915 graduate of the University of Illinois College of Medicine.

**Wagner, Leonard M., M.D.**, San Ramon, California, died August 24, 1981 at the age of 77. Dr. Wagner was a 1935 graduate of the Loyola University Stritch School of Medicine.

**\*Weedman, Richard M., M.D.**, Rockford, died November 13, 1981 at the age of 30. Dr. Weedman was a 1978 graduate of the University of Illinois College of Medicine.

**\*Xelowski, Thaddeus, M.D.**, Park Ridge, died December 23, 1981, at the age of 71. Dr. Xelowski was a 1938 graduate of the Loyola University Stritch School of Medicine.

**\*Young, Francis W., M.D.**, died December 20, 1981, at the age of 72. Dr. Young was a 1935 graduate of the Loyola University Stritch School of Medicine.

**\*Zackler, Jack, M.D.**, Tel Aviv, Israel, died November 25, 1981 at the age of 64. Dr. Zackler, a former Chicago resident, was a 1942 graduate of the University of Illinois College of Medicine.

## EKG

*(Continued from page 81)*

**Answers: 1. B, C, D 2. A, D**

The rhythm strip shows a sinus bradycardia at a rate of 50 beats per minute with some sinus arrhythmia best demonstrated in the top strip. All beats are preceded by a P wave with a PR interval of 0.22 seconds for a diagnosis of first degree atrioventricular block. The striking feature of the rhythm strip is the widened QRS beat with the elevated ST segment. Since all of these beats are preceded by a P wave with a consistent PR interval, they are conducted beats with a bundle branch block pattern. These beats showing bundle branch block appear after relatively long R-R cycles up to 1280mSec while the beats with a normal QRS duration generally have R-R cycles less than 1200mSec. This is bradycardia dependent bundle branch block. Another term for this is phase 4 block. It implies that spontaneous diastolic depolarization is occurring in that bundle branch. This makes the tissue refractory to conducted beats and a block occurs. Our patient also showed left bundle branch block at the rapid heart rates generated by atrial fibrillation. This is known as tachycardia dependent bundle branch block or phase 3 block. It implies the beats are so fast and the cycle so short that the relative refractory period of the preceding beat is being impinged upon. Our patient showed a normal QRS only at heart rates in the high fifties. Digoxin was held because of a suspicion that the sinus bradycardia was an early manifestation of digitalis toxicity. More digoxin or propranolol could have made the sinus rate even slower. ◀

\* Indicates ISMS member

\*\*Indicates member of the ISMS Fifty Year Club

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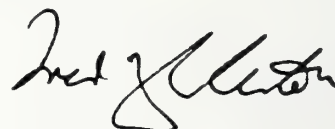


rapidly as more physicians join groups or work for hospitals and outpatient centers. Physicians taking part in HMOs, IPAs, or other alternative delivery systems are quickly losing their minority status.

This evolution from what has been characterized as a cottage industry to a more efficient system will not be without a cost. Predictably, there will be less personalization and more non-medical bureaucracy.

This may present another dilemma, in that society is presently expressing discomfort with the high technology, high cost medical system. The significant counterbalance to this has been the personal relationship of the physician and patient. Without this personal relationship, we may be left with an impersonal, high-technology-at-the-lowest-bid system which may ultimately please no one.

Clearly then, forces for change are present, and the fact that significant change will occur cannot be denied. We in our county medical societies and within the structure of ISMS must accept this as a reality and respond realistically. This response should be through involvement in the transition so we can preserve all that is good in our present system and not be swept aside as the corporate systems and efficiencies evolve. ◀



Fred Z. White, M.D., President

## Faculty Member Family Practice Program

The Black Hawk Area Medical Education Foundation is recruiting a Board Certified Family Physician to join its Family Practice Residency Program in Waterloo, Iowa. The program is community-based, affiliated with the University of Iowa College of Medicine, and part of the Iowa Network of Family Practice Residency Programs. The Waterloo metropolitan area has 125,000 people, four hospitals, and is well represented in the medical specialties.

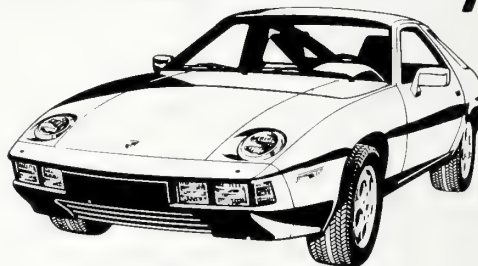
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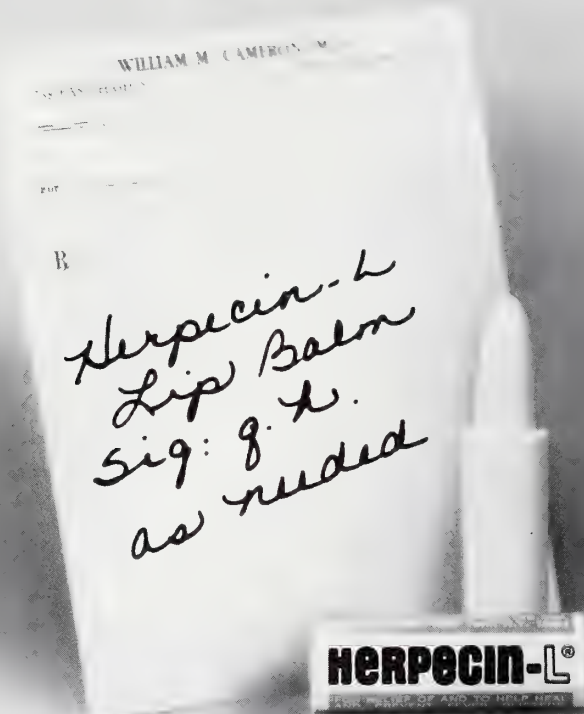
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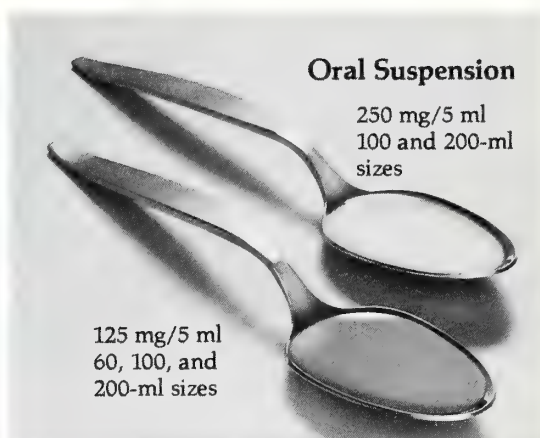
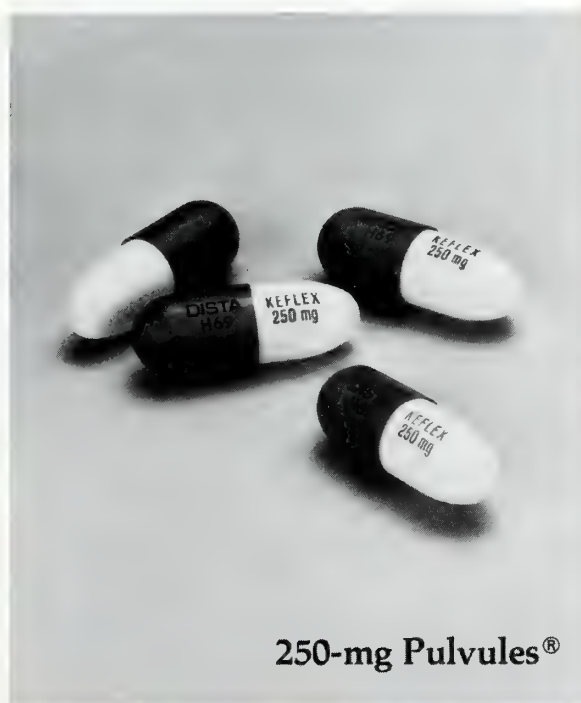


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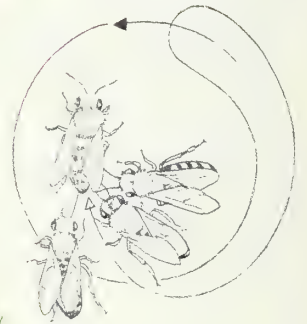
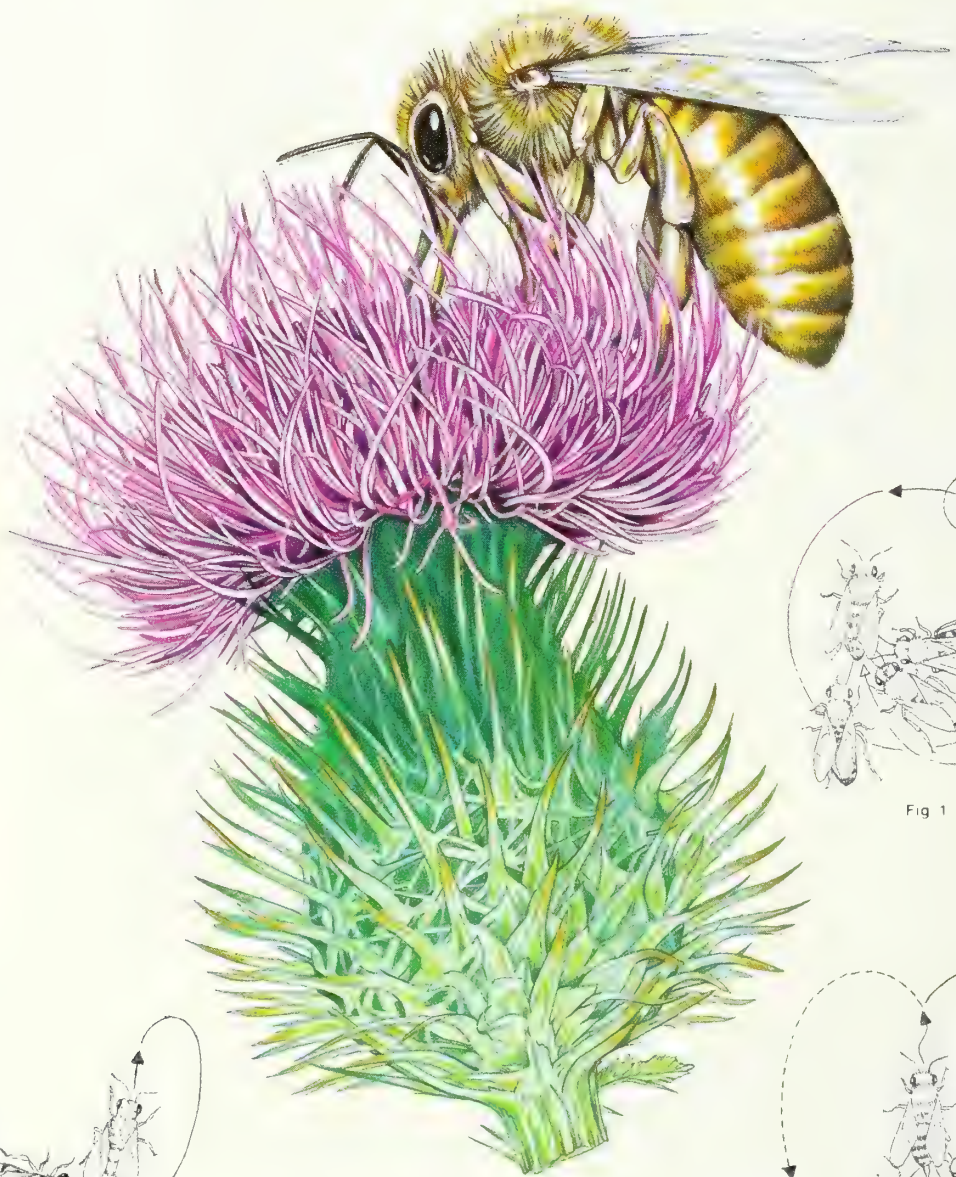


Fig 1

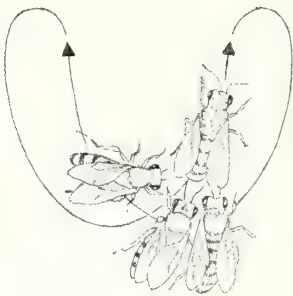


Fig 3

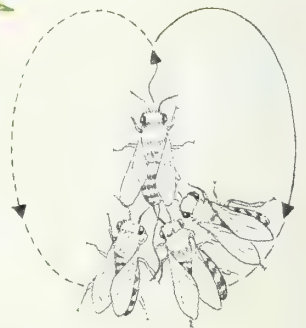


Fig 2

*Apis mellifera* Linnaeus

## BEE LANGUAGE.

The dance patterns formed by honeybees in flight are specifically designed to communicate where and how far away a source of nectar lies.

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Another pattern (Fig. 2) is called the "wagging dance." The bee moves forward in the direction of the nectar while wagging its bottom, then flies back to its starting place. The faster the wagging, the nearer the nectar.

The "sickle dance" (Fig. 3) is a pattern used by Italian honeybees to indicate intermediate distances. The opening of the "sickle" faces the source of the nectar; the vigorousness of the dance indicates the quality of the nectar. This degree of specificity in communication is unusual in nature.

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**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

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# Medical Student Section in Action

## Interim Meeting Update

The 1981 Interim Meeting of the ISMS House of Delegates was held November 7-8, 1981, in Springfield. The Medical Student Section (MSS) was represented by Malcolm Major, acting as delegate, Michael Nieder, Kurt Elward and Linda Tetzlaff of the MSS Governing Council and representatives of nearly all medical schools in the state.

A number of resolutions submitted by the MSS were deferred by the House until the annual meeting in April. Specifically, these resolutions called for 1) investigation of alternative funding sources for inner city hospitals, and 2) development and dissemination of information concerning the efficacy of motorcycle helmets and seatbelts.

An MSS resolution calling for reduction or elimination of fees for students and residents at ISMS-sponsored seminars and workshops was also not submitted for a House vote, since it had been accepted by the Board of Trustees as an administrative change. Another MSS resolution calling on physicians and other health care providers to discuss and encourage the use of infant car seats with their patients was combined with a similar resolution which asked that physicians be made aware of specific features which have been proven effective.

An MSS resolution calling on the ISMS to support legislation requiring stiffer sentences for drunk drivers was amended by the House to support a newly passed state law which has substantially stiffened the penalties for this act.

Of greatest impact to a number of the students present was a late resolution which was submitted by the Winnebago County Medical Society concerning the proposed reorganization of the University of Illinois College of Medicine. The resolution, which was supported by the MSS,

asked Stanley O. Ikenberry, president of the University of Illinois and its Board of Trustees to "... recognize the importance of the Regional Medical Centers being semi-autonomous from the Chicago campus, with their own deans and department heads and with academic freedom in organization of their educational structures." This was the result of a special meeting of the general faculty of the University of Illinois. At that meeting, several representatives of the downstate schools expressed a belief that the proposed reorganization would shift the basic sciences-clinical medicine balance from its current one year basic medicine/3 years clinical medicine emphasis to a more conventional 2/2 split while causing drastic administrative changes at the clinical schools in Rockford, Peoria and Urbana.

A great deal of debate ensued during the Sunday session of the House. Several delegates opposed the resolution on the grounds that the University of Illinois, as an educational institution, should be allowed to make its own decisions regarding administrative and curriculum changes. However, students demonstrated that the proposed changes would have a detrimental effect on the ten-year old process of regionalization which has been generally recognized as a positive step toward bringing medical care to the downstate areas, and that such changes would have a negative effect on the quality of education offered to downstate students. The House vote agreed with the students' viewpoint and supported the resolution.

Resolutions for future ISMS meetings should be submitted to school representatives as soon as possible. All authors are requested to determine the current ISMS policy prior to submitting resolutions. ISMS Policy Manuals may be obtained from school representatives.

Malcolm Major  
Alternate Delegate, ISMS/MSS



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# I M J

Illinois Medical Journal

Volume 161, No. 2, February 1982

## Uncommon Malignancies of the Esophagus

BY MUMTAZ CHINYOY, M.D. AND CESAR V. REYES, M.D./HINES

*Esophageal neoplasms other than the conventional squamous cell carcinoma are relatively uncommon. In this report, three malignancies infrequently encountered in the esophagus, including adenocarcinoma, malignant melanoma, and carcinosarcoma are briefly presented, with clinical, radiographic and pathologic features. Available data suggest that the biologic behavior of these tumors is no different from squamous cell carcinoma.*

### Primary Adenocarcinoma of the Esophagus

A 62-year-old white man presented with progressive dysphagia and 30-pound weight loss of a few weeks' duration. The physical findings, hemograms, and chemistry data were within normal range. Esophagograms showed an irregular filling defect above the gastro-esophageal junction (Figure 1). Endoscopy revealed a circumferential projecting, obstructive and friable mass with ulceration about 35 centimeters from the incisors. A cytologic brushing and biopsy were interpreted as a well differentiated adenocarcinoma. Esophagogastrectomy and esophagogastrostomy were performed. The primary location in the lower third of the esophagus and glandular histology of the neoplasm associated with benign and atypical

Barrett's epithelium were demonstrated.

The patient was supported with a subclavian hyperalimentation, which maintained his weight. Two months after diagnosis, there was a tumor recurrence in the form of mediastinal lymph node and lung metastases. He rapidly deteriorated and expired two months later.

Primary adenocarcinoma constitutes about 1-8% of all esophageal malignancies as cited in reported clinical series.<sup>1</sup> The definition of the tumor has been emphasized by Turnbull and Goodner<sup>2</sup> and Haggitt, *et al*<sup>3</sup> in the evaluation of its true incidence and related clinical characteristics.

The neoplasm tends to be more commonly seen in Caucasian males aged 50-60 years. The lower third of the esophagus is the usual site of involvement. Its symptomatology, biologic course, and prognosis appear to be similar to that of the ordinary esophageal squamous cell carcinoma.<sup>1-3</sup>

Esophageal adenocarcinoma has traditionally been considered to originate from ectopic gastric glands and submucosal glands based on its histologic resemblance to corresponding gastric gland and salivary gland cancers. However, the consistent association of Barrett's epithelium or columnar-lined lower esophagus and adenocarcinoma has now rendered a more widely accepted concept of causal relationship between these two lesions. This observation is supported by the findings of pre-invasive stages in the evolution of adenocarcinoma in Barrett's esophagus, including cellular atypia, dysplasia and *in-situ* changes.<sup>1-4</sup>

**CESAR V. REYES, M.D.**, is a board certified anatomic and clinical pathologist affiliated with Hines Veterans Administration Hospital. An assistant professor, department of pathology, University of Illinois School of Medicine, Dr. Reyes cites special interest in surgical, dermatologic and endocrine pathology.



**MUMTAZ J. CHINYOY, M.D.**, is a board certified radiologist affiliated with Hines Veterans Administration Hospital. An assistant professor in the department of radiology, Loyola University Stritch School of Medicine, Dr. Chinoy cites interest in ultrasound and lymphangiography.



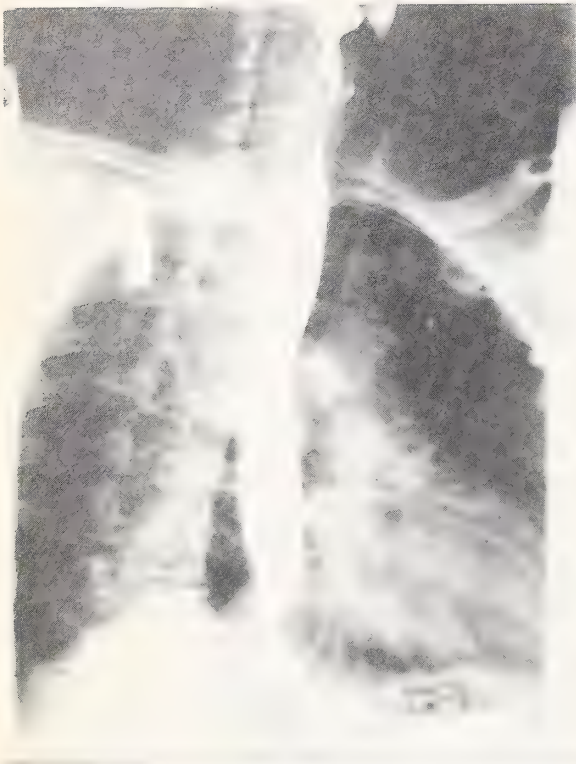


Figure 1

A right oblique view esophagogram showing a filling defect above the gastro-esophageal junction with step-like transition to the segment above.

Although some investigators still recognized Barrett's epithelium as a congenital lesion, its development seems to be closely related to chronic reflux esophagitis and hiatus hernia. Histologically, it appears to be heterogenous and consists of three patterns, namely: (1) atrophic gastric fundic type of epithelium with parietal and chief cells; (2) junctional epithelium with cardiac mucous gland, and (3) specialized columnar epithelium with goblet cells resembling intestinal mucosal tissue.<sup>1-4</sup>

Available clinical and experimental data have also indicated premalignant potential of Barrett's epithelium. A surveillance follow-up with esophageal cytology and biopsies is important. Similarly, it has been suggested that the findings of esophageal columnar epithelium in patients with chronic history of reflux esophagitis should be regarded as an indication for an anti-reflux operation.<sup>1-4</sup>

#### Primary Malignant Melanoma of the Esophagus

A 58-year-old white man complained of dysphagia and hematemesis of four weeks duration. A thorough and clinical investigation and physical

examination were non-revealing. Laboratory data were within normal range. Repeated esophagograms demonstrated a localized dilatation of the upper thoracic segment with a fungating filling defect (Figure 2). Esophagoscopy and biopsy at about 23 centimeters disclosed a necrotic, hemorrhagic and polypoid lesion which was interpreted microscopically as undifferentiated malignant tumor. Esophagectomy, pyloroplasty, and gastrostomy, followed by a colon interposition, were all tolerated well. The resected esophagus showed a sessile to polypoid, reddish gray, and focally ulcerated tumor of 8.5×6×3.5 cm. Histologically, a carcinomatous and spindle cellular pattern was exhibited by the tumor with prominent intraepithelial spread of neoplastic cells and brown pigments identified on special stains as melanin. By electron microscopy, cytoplasmic premelanosomes and melanosomes were abundant, confirming the diagnosis of a primary malignant melanoma.

The patient developed a tumor recurrence in two months. Esophageal dilatation was done and a feeding gastrostomy reinstituted. Six months after diagnosis, the follow-up chest radiographs revealed multiple metastatic lesions in both lung fields for which a course of 4,000 rads was administered. A cervical mass subsequently appeared and was microscopically identical to the initial tumor. He began to lose weight and succumbed to his illness about seven months after the initial surgery.

The diagnosis of a primary malignant melanoma of the esophagus, not unlike its cutaneous and other mucosal counterparts, is based on the finding of a junctional melanocytic activity in the overlying or adjacent epithelium. In some rapidly growing and expansile tumors, however, this evidence of junctional melanocytic changes may be effaced. A diagnosis by exclusion, supported by negative, exhaustive clinical investigation and complete postmortem examination for a primary lesion elsewhere, is alternatively accepted. In addition, the entity of secondary esophageal melanoma is much rarer than primary lesion.<sup>5,6</sup>

Histogenetically, the neoplasm is believed to arise from the melanocytes which occur in the basal layer of squamous mucosa in four to eight percent of normal esophagus. Premalignant melanosis either localized or diffusely involving the entire length of esophageal mucosa has been occasionally reported.<sup>5,6</sup>

The ages of patients with esophageal malignant melanoma at the time of diagnosis range from seven to 82 years, with a mean of 61 years. Men predominate with a 2:1 male to female ratio and Caucasians are almost exclusively affected. There

appears to be a close similarity between this tumor and esophageal squamous cell carcinoma in their clinical manifestation, biologic course, and prognosis.<sup>5,6</sup>

### Carcinosarcoma of the Esophagus

A 60-year-old white man entered the hospital

because of increasing dysphagia, marked weight loss, and cachexia for three months. Laboratory data were within normal range. The chest roentgenograms demonstrated a right perihilar soft tissue mass and an air-fluid level in the retrotracheal region. The barium meal examination was interpreted as an irregular tumor in the middle and distal thirds with enlarged mediastinal lymph nodes (Figure 3). Endoscopy at 25cm. revealed a polypoid, obstructive and ulcerated lesion. Several biopsy bites from the neoplasm were uncomplicated. Histologically, the tumor displayed an intramucosal moderately differentiated squamous cell carcinoma overlying a pleomorphic spindle cell type of sarcomatous component. By ultrastructural evaluation, the latter was of mesenchymal nature, exhibiting only rare, ill-formed intercellular tight junctions. The final designation was a carcinosarcoma of the esophagus.

The apparent extensive size of the tumor and deteriorating physical condition of the patient precluded any definitive therapeutic intervention. With supportive and symptomatic regimens, he



Figure 2

An oblique overhead view showing a lobulated filling defect expanding the lumen of the upper third of esophagus.

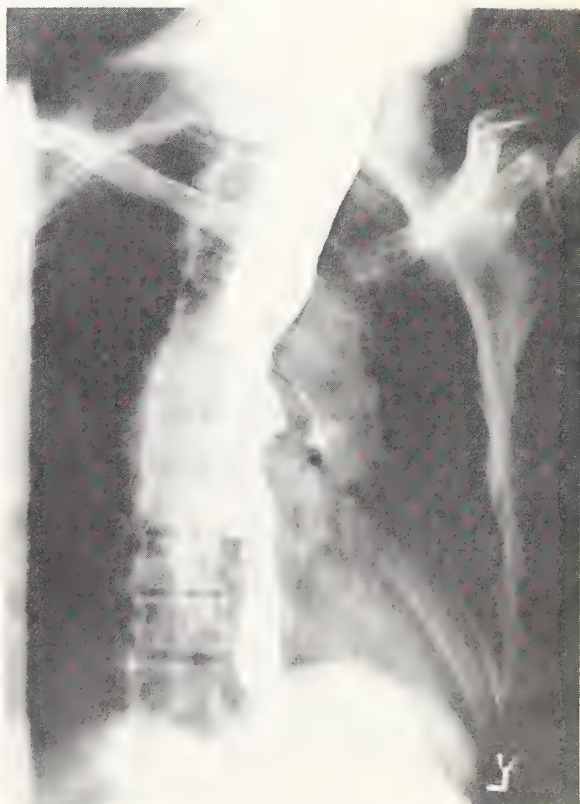


Figure 3

An extensive involvement of the middle and distal esophagus with mucosal destruction and irregular ulcerations.

(continued on page 108)



## An Effective Alternative For Muscle Contraction Headaches

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BY GEORGE L. BAKRIS, M.A., M.D., GEORGE P. MULOPULOS, M.D.,  
SUBHASH TIWARI, M.D., AND CORY FRANKLIN, M.D./CHICAGO

*A prospective, randomized study, comparing the efficacy of diazepam to orphenadrine citrate for relief of muscle contraction headaches, was conducted. Symptomatic improvement of 38 female outpatients was assessed by patient response to drugs at intervals of one week, one month, and six months. Both drugs showed equal efficacy for headache alleviation regardless of duration. After a six month trial, 79% of the diazepam group and 74% of the orphenadrine group reported a decreased incidence of symptom exacerbation. Hence, orphenadrine citrate, with its minimal side effects and comparable effectiveness, may be a preferred alternative to diazepam for symptomatic control of muscle contraction headaches.*

Muscle contraction headache (MCH), a bilateral, diffuse pain extending over the cranium with common occipital-nuchal localization, is associated with muscle spasm, anxiety and depression.<sup>1</sup> It affects 80% of the adult population and

three-fourths of its victims are women.<sup>2</sup>

The chronic management of this symptom has resulted in a plethora of effective prophylactic medications. In recent years, some authors<sup>3,4</sup> have claimed diazepam to be the drug of choice for alleviating MCH. However, this anxiolytic has been associated with psychological and physical dependence, abuse, and withdrawal psychosis.<sup>5</sup>

We feel these anxiolytic attributes are unacceptable and necessitate the use of an alternative agent. Orphenadrine citrate, a central skeletal muscle relaxant, has been shown to possess significant activity for relieving MCH.<sup>6,7</sup> The purpose of this prospective study is to compare the two agents regarding their efficacy for treatment of muscle contraction headaches.

### Materials and Methods

In a random, prospective study, 38 Caucasian females, newly diagnosed as having muscle contraction headache of varying duration, were treated at a public outpatient clinic. All patients described a chronic, constant, headache pain with localization in the occipital-nuchal area, which altered their daily activities and was unresponsive to both aspirin and acetaminophen. Patients with a history of arthritides, neurologic diseases, seizure disorders or migrainous phenomena as well as those receiving other analgesics, tranquilizers, sedatives or anti-inflammatory agents, were excluded from the study. Patients were randomly assigned to two groups. The diazepam group received 5mg. every 8 hours whereas the orphenadrine group received 100mg. every 12 hours. Patients were randomly given unlabeled containers of pills, which stated the number and fre-



**GEORGE L. BAKRIS, M.D.**, is a resident physician in Internal Medicine at the Mayo Clinic in Rochester, Minnesota. At this writing, Dr. Bakris was a medical student at the University of Health Sciences/Chicago Medical School, where he later received a medical degree.



**GEORGE P. MULOPULOS, M.D.**, is an intern in Radiology at Rush-Presbyterian-St. Luke's Medical Center in Chicago. A graduate of the University of Health Sciences/Chicago Medical School, Dr. Mulopulos was a medical student at this writing.

**CORY FRANKLIN, M.D.**, is the attending physician coordinating intensive care units at the University of Illinois Hospitals and Clinics, Chicago. A board certified internist, Dr. Franklin was a resident physician in internal medicine at Cook County Hospital at this writing. He has also served as a fellow in critical care medicine for the Case Western Reserve Hospitals of Cleveland.

**SUBHASH TIWARI, M.D.**, is a board certified psychiatrist affiliated with Horizon Hospital in Florida. Also a board eligible neurologist, Dr. Tiwari cites particular interest in behavioral neurology and hemispheric dominance.

**Table 1**  
**Summary of Headache Response to Drugs**

	Medication		P
	Diazepam	Orphenadrine citrate	
1) <b>Duration of muscle contraction headaches prior to treatment (months):</b>			
Mean SD	10 ± 1.4	9 ± 1.3	NS
Range	6-14	6-12	
2) <b>Median Age</b>	41	38	
3) <b>% Improvement</b>			
One week	90(17/19)	95(18/19)	NS
One month	79(15/19)	84(16/19)	NS
Six months	79(15/19)	74(14/19)	NS

quency with which the pills were to be taken. An assistant dispensed and refilled all medications as prescribed by the protocol. Follow-up visits were conducted at one week, one month, and six month intervals. At these periods patients were asked if headache symptoms had improved and what side effects they experienced. A positive response was defined as alleviation of headache symptoms so that pain did not interfere with daily activities. Slight improvement of persistent pain constituted unresponsiveness to medication if it interfered with daily activities.

The point-biserial correlation (t) and chi-square ( $\chi^2$ ) tests were used to assess statistical significance of nominal data. The results were considered significant when ( $P < 0.05$ ).

## Results

Eighty-three female patients were evaluated; thirty-eight (46%) met the criteria for study. The age of the entire group was  $38 \pm 1.2$  (mean  $\pm$  SEM) with a range from 21 to 59 years.

After one week of medication, three people dropped out of the study, reporting no significant benefit from treatment.

Table 1 summarizes the data. Neither group demonstrated a significant difference between mean duration of headache symptoms prior to treatment and symptom alleviation. In addition, no significant difference was observed in drug effectiveness for symptom relief after one week, one month, and six month periods.

Table 2 lists the most common side effects observed with both drugs. Other commonly reported adverse effects of these drugs, *i.e.* tolerance and withdrawal insomnia with diazepam and constipation with gastrointestinal upset with orphenadrine citrate, were not reported by our population.

## Comment

Diazepam and orphenadrine citrate have dem-

**Table 2**  
**A Summary of Side Effects Observed in 38 Female Patients with Muscle Contraction Headaches**  
**Total No. (%)**

	Diazepam	Orphenadrine citrate
Drowsiness	18(95)	0
Weight gain	4(21)	0
Skin rash	1(5)	0
Dry mouth	0	19(100)
Dizziness	0	2(11)

onstrated efficacy for treatment of muscle contraction headaches.<sup>3,4,6,7</sup> Our data give further support to these findings. Headache duration prior to therapy was not a factor in symptom improvement. In addition, no significant difference in effectiveness over a six month period was observed in either group. These data reveal both drugs possess equal efficacy for alleviation of muscle contraction headaches.

Many other drugs<sup>8</sup> have been utilized for relief of MCH, although most are not used for long term treatment or prophylaxis. The more popular classes of analgesics and narcotics do not possess anti-anxiety or muscle-relaxant properties.<sup>9</sup> Furthermore, long term use of these agents can lead to nephropathy, gastrointestinal complications, hemorrhagic diatheses and addiction.<sup>10</sup> Barbiturates in therapeutic doses have no muscle-relaxant properties and can result in physical dependence, drug interference by enzyme induction, and increased risk of suicide.<sup>11</sup> Benzodiazepines, notably diazepam, possess both direct anti-anxiety and indirect muscle-relaxant properties, attributes which quell most cases of MCH. Unfortunately, prolonged use of this drug has demonstrated a potential for addiction.<sup>12</sup>

Orphenadrine citrate has demonstrated efficacy for treatment of MCH; its relative disuse is unexplained. It acts on the higher levels of the central



nervous system interfering with reflex pathways for pain and skeletal muscle contraction. The resultant effect is spasmodic contraction of skeletal muscle without reduction in the general muscle tone.<sup>13</sup>

A comparison of effective dosage schedules reveals orphenadrine citrate to be clearly more convenient and void of any psychological or physical dependence.<sup>14</sup> Furthermore, toxic reactions in humans from gross overdosage have never been reported.<sup>15</sup> Chronic administration of ten times the recommended clinical dose of orphenadrine citrate to dogs and rats produced no toxic effects.<sup>16</sup> In light of these facts and the chronic nature of muscle contraction headache, orphenadrine citrate appears to be an excellent alternative to the commonly prescribed anxiolytics.

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## Uncommon Malignancies of the Esophagus

(continued from page 105)

followed a rapid downhill course and died a little over one month after diagnosis.

Carcinosarcoma, also referred to as spindle cell carcinoma or pseudosarcoma, is more commonly seen in the mouth, faces, upper respiratory tract and skin. Some cases developed after radiation therapy for either benign lesions or typical squamous cell carcinoma.<sup>7,8</sup> The neoplastic cells mimic fibroblasts and usually exhibit abundant tonofilaments and desmosomal structures, supporting an epithelial derivation of the tumor.<sup>7,8</sup> Less often, these fine structural hallmarks of an epithelial cell are not observed, as exemplified by the present case. The bulky and pedunculated growth along with the histological features of the tumor are characteristic.<sup>7,8</sup>

The earlier reports of carcinosarcoma and the so-called pseudosarcoma or spindle cell carcinoma of the esophagus have usually separated these two tumors into distinct entities. Recently, however, there is a tendency to lump these lesions into one disease on the basis of metastatic potential of both histologic components and their very nearly identical clinical behavior. The term polypoid carcinoma with spindle cell sarcomatous features, has been proposed for all combined epithelial and spindle cell malignancies of the

esophagus.<sup>8</sup>

In the same context, at least half of the previously recorded cases—approximately 23 carcinosarcomas and 20 pseudosarcomas—seem to follow a rapidly fatal course that is akin to the more conventional squamous cell carcinoma of the esophagus.<sup>7,8</sup> ◀

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# Rheumatology Rounds

L. F. Layfer and J. V. Jones, Contributing Co-Editors

## Shin Pain in a Ballet Dancer

BY MARK J. ROUND, M.D. AND BRUCE M. ROTHSCHILD, M.D./CHICAGO

A 19 year old white female ballet dancer had first noted repetitive episodes of aching shin pain six months before this visit. The pain was insidious in onset, exacerbated by prolonged ballet practice, and ameliorated by rest. Eleven months earlier, she had "broken training" but she had resumed her practice schedule a month before onset of pain. Past history and review of systems were unremarkable. Positive physical findings were limited to hypermobility of the joints and

focal areas of tenderness on the anterior aspects of both tibia.

Laboratory evaluation of Westergren erythrocyte sedimentation rate, complete blood count, serum alkaline phosphatase, calcium and phosphate were normal. The initial roentgenograph was unremarkable. Technetium 99 pertechnetate bone scan revealed focal areas of increased uptake in both tibia. (Figure 1) The repeat X-ray (Figure 2) obtained one week later revealed focal oblique radiolucent clefts in the tibia.

### Discussion

This case illustrates an entity in which discomfort in a young adult occurs with exercise, abates with rest, and recurs with similar exertion. The clinical picture is typical for stress fractures. The differential diagnosis must include osteomyelitis and bone tumors, but the X-ray findings eliminate the more serious possibilities.<sup>1,2</sup>

Stress fractures occur in children and young adults in response to unaccustomed submaximal repeated stress forces which promote bone resorption.<sup>1,2</sup> The incidence of stress fractures is proportional to the period of unconditioned strenuous activity.<sup>3</sup> The first symptom, exercise induced discomfort, may resolve with rest. The

**Mark J. Round, M.D.**, is chairman of the department of medicine, Good Shepherd Hospital, Barrington. An internist in private practice, Dr. Round has also served as an instructor in the department of medicine at the University of Health Sciences, Chicago Medical School.



**Bruce M. Rothschild, M.D.**, is a board certified rheumatologist and internist affiliated with the Veterans Administration Medical Center, North Chicago. The director of the division of rheumatology, Chicago Medical School, Dr. Rothschild holds several professional and community service positions. He is

both chief of the section of rheumatology and chairman of continuing education for the department of medicine at the North Chicago Veterans Administration Medical Center.





**Figure 1**  
Technetium 99M scan at 2 hours post injection.



**Figure 2**  
Radiograph obtained one week after scan. Linear defects in the cortex are apparent.

discomfort, however, recurs with reinstitution of similar, unconditioned repetitive activity.<sup>4</sup>

Physical examination may only reveal areas of tenderness. Edema may occur within three to 10 days of stress fracture occurrence. This edema may be focal or diffuse, pitting or nonpitting, and will resolve within three weeks.<sup>1,4</sup> Skin overlying the stress fracture may be warm, erythematous and occasionally ecchymotic. If a large subperiosteal hematoma forms, periosteal elevation may be palpable. Systemic symptoms are usually absent.

A radiographic finding commonly noted in stress fractures is an oblique radiolucent cleft which resembles a knife slice,<sup>2</sup> as seen in Figure 2. An area of periosteal overgrowth near the stress fracture may result in smudging, loss of distinction, or sclerosis of the periosteum.<sup>1</sup> A severe stress fracture may resemble a crush injury.

If the initial roentgenograph is negative, the film should be repeated in one to two weeks. If the causative activity is halted, repeat films should

evidence healing. In the absence of radiographic evidence of healing, a bone biopsy should be performed to establish a diagnosis.

With negative initial radiographs, a Technetium 99M bone scan should be performed. The scan will demonstrate focal areas of increased uptake at the site of stress fractures.

The tibia is involved in about 12% of patients with stress fractures.<sup>1,2,4</sup> As indicated in Table 1, these fractures are generally related to cross country running or to ballet. The tibial plateau and the proximal or distal shaft are the areas most commonly involved.

Treatment of stress fractures requires cessation of the repetitive activity which precipitated the fracture.<sup>2,4</sup> Continuing the stress-inducing activity may result in a complete fracture, which heals more slowly than normal fractures. Analgesics and cold compresses are used to control discomfort. Gradual resumption of conditioned efforts following a short period of bed rest will allow the disorder to resolve. Immobilization during the

**Table 1**  
Correlation of activity with stress fracture localization.

ACTIVITY:	Metatarsal	Navicular	Calcaneus	Tibia	Proximal Fibula	Patella	Femur	Pelvis	Lumbar Vertebrae Para-intra-articularis	Cervical Thoracic Spinal Procedures	Ribs	Clavicle	Coracoid	Distal Humerus	Proximal Ulna	Hook of Hamate
<b>Sports:</b>																
Ballet	X			X			X		X							
Baseball																X
Bowling								X								
Cross country running		X		X			X									
Discus														X		
Golf											X					X
Gymnastics							X	X								
Javelin														X	X	
Jumping			X		X											
Parachuting			X		X											
Pitching														X	X	
Tennis											X					X
Trapshooting													X			
<b>Occupational:</b>																
Coughing											X					
Digging										X						
Heavy lifting									X							
Extensive walking	X	X														
Marching	X	X														
Scrubbing floors									X							
Shoveling										X						
Standing for ext. periods	X		X													
Stooping								X								
Using pitchfork															X	
<b>Activities of Daily Living:</b>																
Learning to walk (child)									X							
Propelling wheel chair															X	
Rotatory activity															X	
<b>Iatrogenic:</b>																
Immobilization			X													
S/P bunionectomy	X															
S/P radical neck												X				

period of bed rest is to be avoided since it would only prolong symptoms and delay healing.<sup>3</sup> ◀

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# Sports Medicine

*The increased incidence of sports-related injuries has paralleled the fitness boom and the tremendous rise in participation in athletic competition. Treatment of such injuries has become part of the practice of a rapidly-growing number of physicians. At the same time, school boards and others responsible for athletic programs are exhibiting heightened interest in injury prevention and treatment.*

## The Role of the Team Physician In School Athletics

BY H. BATES NOBLE, M.D. AND MARIANNE PORTER, M.A., A.T.,C./CHICAGO

*This is the first in a series of articles prepared under the direction of the ISMS Sports Medicine Committee that will focus upon clinical sports medicine topics and related issues. The series is intended to broaden clinical knowledge, aid the physician in educating patients on preventive measures and, hopefully, stimulate physician involvement in activities designed to protect the health of young athletes. The Committee welcomes your comments and suggestions.*

Civic and sports-minded physicians have always given time and talent to provide medical coverage for interscholastic athletic events. The degree and extent of an individual physician's involvement in school athletic programs has been highly variable and rarely well defined. This paper will seek to provide guidelines for physicians and schools who may wish to establish a "team physician" relationship.

Before attempting to offer himself as medical savior of school athletes, the physician should acquaint himself with the medical aspects of sport. There are a number of available courses, publications, and books dealing with sports medicine. A list of sports medicine publications and courses is available from the ISMS Sports Medicine Committee. The physician should understand in-

jury recognition, equipment fitting, conditioning, on-field protocol, and the physical requirements of, or criteria for participation in, the given sport.

It would appear that the team physician's potential liability has received too much emphasis. Despite a relatively hostile malpractice climate, there have been strikingly few suits launched against individuals serving as team physicians. As in most medical litigation, lawsuits seem to result more often from poor communication than real "mal"practice. The physician who can establish a good working relationship with players, coaches and parents need not forego that satisfaction and enjoyment for fear of possible lawsuits.

We have found that most school administrators have little idea how to find a team physician or

have been rebuffed so often that they've given up. It is not unseemly for a conscientious physician to seek out the local school athletic director and offer his assistance. In most instances, the administrator will be overjoyed by the offer. It is not necessary to have a child involved in school athletics or to be an orthopaedic surgeon, to be an effective team physician.

Many physicians are concerned about the time commitment necessary to adequately cover a school's athletic program. This fear is justified, but can be well handled if several physicians share the load. We would like to see the recent reactivation of the ISMS Committee on Sports Medicine spawn numerous similar committees at the local medical society level. These groups could effectively organize not only medical coverage for student athletics but also educational programs for physicians, athletes, coaches, officials, and parents.

### Education and Prevention

The most effective medical practice is preventive. Education plays the major role in this aspect of sports medicine. The pre-competition evaluation is also important in injury prevention. A pending article in this series will detail approaches to the pre-competition medical evaluation. We believe that the best pre-competition evaluation is done by the team physician(s) on a group basis. This affords the opportunity to consider physiologic matching and introduces individual histories and pre-existing conditions. These may be relevant to the physician's assessment of an athlete's condition should an injury occur. We believe that this approach is better than sending rudimentary evaluation forms home with the athletes to be completed by a family physician. These forms are sometimes forged by parents who fail to comprehend their importance.

The team physician must be actively involved in planning for the season. He should help develop and supervise the pre-season conditioning programs, which demonstrably reduce injury potential. (An article concerning pre-season conditioning will appear in a future segment of this series.) A contingency plan must be formulated for serious injuries either during practice or in a game situation. Who will call an ambulance? Are adequate supplies available to handle medical problems? Who is directly responsible at the site of injury? Are they adequately trained to handle first aid situations? CPR? Is the coach planning a practice in full uniform on the hottest, most humid afternoon of August?

If the team physician is fortunate enough to have the services of a certified athletic trainer,

many of these planning chores are the trainer's responsibility. Unfortunately, recent studies have shown that few schools have a certified athletic trainer.<sup>1</sup>

The team physician should attend all home athletic contests in contact sports and be on call for practices and away games. Obviously, the team physician must not only enjoy watching sports events, but also have time to devote to their coverage.

While deference must be paid the individual participant's personal physician and that relationship remain intact, the team physician should have complete control of all medical judgments regarding playing status and initial treatment of injured athletes. When the star halfback has had his "bell rung" and the team physician indicates that he must remain out of competition for the remainder of the game, there must be no negotiation with the coach, player, or parents. The ease with which this can be done depends on the relationships previously established by the physician as "team doc." When a medical problem arises, the team physician can facilitate rapid treatment, even though he may not be the athlete's personal physician.

### Summary

Practicing as a "team physician" is an exceptionally rewarding experience. It affords the physician an excellent opportunity to teach, practice preventive medicine, deal with emergent situations, have contact with and assist a delightful group of healthy young people. ◀

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**Marianne T. Porter** is assistant director, Northwestern University Medical School Center for Sports Medicine. A certified member of the National Athletic Trainers Association, Ms. Porter is a former member of the Illinois Governor's Task Force on Athletic Injuries. She has served as a coach and high school physical education instructor, and is a member of the American College of Sports Medicine, Illinois Athletic Trainers Association and National Athletic Trainers Association.

**Howard Bates Noble, M.D.**, is director of the Northwestern University Medical School Center for Sports Medicine and an assistant professor in surgery, Northwestern University Department of Orthopaedic Surgery. A diplomate of the American Board of Orthopaedic Surgery, Dr. Noble is a member of the ISMS Committee on Sports Medicine. He is current team physician for the Chicago Bulls and former team physician for the Chicago Hustle (women's professional basketball). Dr. Noble is also an examiner for the American Board of Orthopaedic Surgery and a member of both the Governor's Council on Health and Fitness and the ISMS Council on Public Relations.



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# Case Reports

## Multiple Primary Malignant Neoplasms

BY CRAIG D. FRIEDMAN and JOHN R. MCCARTHY, M.D./CHICAGO

*An unique case of multiple primary malignant neoplasms is presented. Important clinicopathologic points are discussed.*

Theodore Brillroth was the first to clearly document examples of multiple primary malignant neoplasms (MPMN) in a single individual.<sup>1</sup> The occurrence ranges from 3.2% to 4% of all cancer patients<sup>2-4</sup> and is higher in certain select patient groups. We report here the case of a patient with three primary malignant neoplasms originating in different organs compatible with Class II in Moertel's classification<sup>5</sup> (Table 1) and fulfilling the criteria of Warren and Gates.<sup>6</sup>

A 66-year-old white female was seen by her family physician for evaluation of personality changes and memory difficulties in recent months. Family members said the patient had become apathetic, more withdrawn, and unable to manage her personal affairs recently. There was no history of headaches, weakness, visual problems or loss of consciousness. The patient had been taking Chlorthalidone® for her hypertension.

The patient had had a left radical mastectomy sixteen years before. The pathology report had cited infiltrating ductal carcinoma, axillary nodes negative. A year after that surgery, the patient underwent resection of her transverse colon for an adenocarcinoma Stage B<sub>2</sub> (modified Dukes classification).<sup>7</sup> No chemotherapy or radiotherapy was given and she had been free of metastatic disease in the interval.

Neurologic examination revealed the patient to be bradyphrenic with decreased concentration. No parasympathetic phenomenon was noted. The neck was supple and no bruits were detected. The right pupil was 3mm. and the left pupil was 2mm. Both pupils reacted to light and accommodation. A mild left central facial weakness was noted. The remainder of the cranial nerve exam was within normal limits. Evaluation of motor and coordination revealed a slight left pronator sign and weakness in

the left upper extremity. The right plantar was flexor, but the left plantar was equivocal. Sensory function was intact.

A computed tomographic scan of the head showed an enhancing mass in the right frontal lobe extending posteriorly to the parietal region and across the midline slightly to the left, with areas of irregular calcification. With additional workup favoring a primary brain tumor a right frontal craniotomy with surgical extirpation of tumor involving right frontal lobe was performed. The pathological diagnosis was a malignant mixed glioma of the brain, both glioblastoma multiforme and digodendroglioma.

### Discussion

This unusual case of three primary malignant neoplasms brings to focus several important considerations for the physician treating cancer patients.

*Patient with Cancer of Multicentric Origin*—The patient with carcinoma of the upper aerodigestive tract has been shown in one particular study to be at 14 times increased risk for development of a second primary.<sup>8</sup> Examples in other organ systems can be cited and such considerations should play an essential role in clinical management and follow-up.

*Patient With MPMN of Different Organ Systems*—The phenomenon of a colon carcinoma in a patient with a previous history of breast cancer has been noted to be of increased incidence.<sup>9,10</sup> Cognizance of such information will aid in early

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**JOHN R. MCCARTHY, M.D.**, is a board certified family practitioner affiliated with Resurrection Hospital in Chicago. Dr. McCarthy is an assistant clinical professor in the department of community and family medicine, Loyola University Stritch School of Medicine. He is a former medical and dental staff president at Resurrection Hospital and a member of the American Academy of Family Physicians.

**CRAIG D. FRIEDMAN** is a fourth year student at the Chicago Medical School. He has served as a student delegate to the Illinois State Medical Society and a Councilor of the Chicago Medical Society. Mr. Friedman is a member of the Chicago Medical Society Student Governing Board and a former research associate in chemistry and pharmacology at Vanderbilt University Medical School, Nashville, Tennessee.



Table 1

Classification of Multiple Primary Malignant Neoplasms

- I. Multiple primary malignant neoplasms of multicentric origin.
  - A. The same tissue and organ.
  - B. A common, contiguous tissue shared by different organs.
  - C. The same tissue in bilaterally paired organs.
- II. Multiple primary malignant neoplasms of different tissues or organs.
- III. Multiple primary malignant neoplasms of multicentric origin plus a lesion(s) of a different tissue or organ.

After Moertel, 1977

detection of the second malignancy during periodic examination. It should also aid evaluation of diet, endocrine abnormalities, and environmental exposure in the development of such neoplasms.

*Therapeutic Implications*—With continued progress in the development of therapeutic modalities for cancer, the carcinogenic role of radiotherapy and anticancer drugs resulting in second primary malignancies should be continually scrutinized<sup>11</sup>.

*Immunologic Perspectives*—The possibility of identifying subgroups of cancer patients capable of generating an immune rejection response holds great promise. Such a response improves survival<sup>12</sup> and supports belief that a previous cancer provides protection against development of a second neoplasm. Immunopharmacology should modulate such responses and help elucidate basic molecular immunology.

In conclusion the occurrence of MPMN, although not common,

raises several important considerations in the clinical management of all patients with malignant neoplasms. Recognition of these significant trends by the physician can serve to improve the clinical outlook. ◀

## References

A complete list of references for "Multiple Primary Malignant Neoplasms," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.

# Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the fol-

lowing style and order: Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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**References:** 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Sambhi MP, Eggena P, Barrett JD, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin angiotensin system in patients with essential hypertension, in Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*. New York: Stratton, 1976, pp 221-245. 3. Pilewski RM, Scheib ET, Misage JR, et al: Technique of controlled drug assay in hypertension: V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971. 4. Fotiu S, Mroczek WJ, Davidov M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974. 5. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976. 6. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1975. 7. Puschett JB: Physiologic basis for the use of new and older diuretics in congestive heart failure. *Cardiovascular Medicine* 2:119-134, 1977. 8. Craswell PW, Ezat E, Kopstein J, et al: Use of metolazone, a new diuretic, in patients with renal disease. *Nephron* 12:63-73, 1973. 9. Bennett WM, Porter GA: Efficacy and safety of metolazone in renal failure and the nephrotic syndrome. *J Clin Pharmacol* 13:357-364, 1973. 10. *Drug Topics Red Book* 1981, and manufacturers' suggested prices.

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# Doctor's News

**RESOLUTIONS DEADLINE**—The ISMS House of Delegates' annual meeting will convene Friday through Sunday, April 16-18, at the Chicago Palmer House hotel. Resolutions for the House of Delegates must be *received* in the ISMS offices by March 17, 1981. Those received after that date will be considered late resolutions and require special action for possible consideration.

In accordance with House policy, resolutions will be published in the *Journal* by author and subject only. Resolutions which were received in the ISMS offices by an earlier deadline, February 12, 1982, will be published in the *IMJ*.

**LICENSE RENEWAL REMINDER**—All Illinois medical licenses will be subject to renewal by the Illinois Department of Registration and Education as of July 31, 1982. Forms for license renewal will be mailed to physicians by the Department this Spring.

The Department mails license renewal forms to the "address of record," that is, the address listed by the physician at the time of 1980 license renewal. If the mailing address has changed in the interim, the physician is obliged to notify the Department.

A new law passed in the most recent legislative session gave the Department regulatory authority to set license expiration and renewal dates. By emergency rule last month, the medical license expiration and renewal date was set at July 31.

Illinois law requires that continuing medical education (CME) credit be earned during the two year period ending March 31, 1982. At least 50 hours of Category 1 CME credit and an additional 50 hours of Category 2 credit must be earned by each physician during the two year period from April 1, 1980 through March 31, 1982. Of the 50 hours Category 1 credit, a minimum of 20 must be part of an approved, formal educational program as specified in the Medical Practice Act. The balance may fall into the realm of approved teaching or medical care audit activities.

Medical licenses are renewed on July 31 of each even-numbered year. Failure to renew on time results in a late fee penalty, and also could jeopardize liability insurance coverage. Further information may be obtained by contacting the Medical Licensure Section, Department of Registration and Education, 320 W. Washington St., Springfield IL 62786; (217) 785-0800.

**SPORTS MEDICINE UPDATE**—The ISMS Sports Medicine Committee has initiated an effort to identify team and sports medicine physicians around the state. Such physicians are asked to write the Committee, c/o ISMS, 55 E. Monroe, Suite 3510, Chicago IL 60603, and identify organized and recreational teams assisted. The Sports Medicine Committee plans to contact physicians in their specialty about local educational programs and a new statewide team physician recognition program.

In a related note, the ISMS Sports Medicine Committee will sponsor a session at the Chicago Medical Society Midwest Clinical Conference.

Specialists in gynecology, neurology, orthopedics and urology will address, "Evaluation for Athletic Competition: Relative and Absolute Contraindications." The program will be held Saturday, March 13, 8:00-11:30 a.m., at the Chicago Conrad Hilton hotel. Hour-for-hour Category 1 CME credit will be awarded to participants.

Further information about the program and the Midwest Clinical Conference may be obtained through the Chicago Medical Society, Division of Professional and Community Education, 515 N. Dearborn St., Chicago IL 60610.



**PHYSICIANS IN THE NEWS**—**John M. Beal, M.D.**, Chicago, has been named president-elect of the American College of Surgeons. Dr. Beal has long served as editor of the *IMJ Surgical Grand Rounds* column.

Newly appointed members of the medical staff at Saint Francis Hospital, Evanston are **Gail Buckman, M.D.**, Chicago, **Lewis M. Cohen, M.D.**, Northbrook, **Razia Hassan, M.D.**, Chicago, **David R. Lewis, M.D.**, Elgin, **Albert J. Saporta, M.D.**, Chicago, **Fuad Ziai, M.D.**, Elmhurst, **Merrill J. Zahtz, M.D.**, Chicago and **Robert Hammerman-Rozenberg, M.D.**, Skokie.

The American College of Physicians has announced that **Viswanatham Susarla, M.D.**, Elgin, has been elected to fellowship in that Society . . . . The American College of Allergists recently named **Donald W. Aaronson, M.D., J.D.**, Chicago, to serve as a member of their Board of Regents. The College also announced that **Robert J. Becker, M.D.**, Joliet, is one of three physicians awarded the honorary title, "Fellow Distinguished." Dr. Becker was cited for work in development of clinical postgraduate education programs.

The 1981 Chicago Press Club "Chicagoan of the Year," award went to **Henry B. Betts, M.D.**, executive vice president and medical director, Rehabilitation Institute of Chicago. The award cited Betts' vision and drive, which "contributed to the establishment in Chicago of one of the outstanding centers for rehabilitation in the nation."

Five ISMS members will serve as members of the Illinois Department of Public Health Perinatal Advisory Committee, on appointment by the Governor. They are **William Hamilton, M.D.**, Carbondale, **John McLaughlin, Jr., M.D.**, Joliet, **Carl Neuhoﬀ, M.D.**, Peoria, **Gerald Staub, M.D.**, Rockford and **Darrell Statzer, M.D.**, Decatur. The Governor's office has also announced that ISMS First Vice President **Robert P. Johnson, M.D.**, Springfield, has been appointed to serve on the Department of Registration and Education Medical Examining Committee.

**JCAH EXTENDS ACCREDITATION CYCLE**—The Joint Commission on Accreditation of Hospitals will replace one and two year accreditation cycles with three-year accreditation for all but long-term care facilities, effective January 1. Corrective actions between the triennial surveys will be monitored through interim JCAH surveyor visits, requests for written information and self-surveys.

**DNR ORDERS**—The ISMS Board of Trustees has mandated that the membership be reminded that if a "Do Not Resuscitate," order is given, it must be written on the order sheet in keeping with JCAH requirements.

**MEDICAL-LEGAL NEWS**—Legislation, which came into effect January 1, 1982, strengthens requirements to be met by persons who prescribe or dispense drugs or medicines. Under this law, all prescriptions for Schedule II substances must show both a written and numerical notation of quantity prescribed. In another provision, the new Act requires that prescriptions for Schedule II controlled substances must be filled within two days of the date the prescription is issued. Both of these provisions affect all Schedule II drugs - including those for which the triplicate prescription form is not required.

Finally, the new law amends the Medical Practice Act (Chapter III, paragraph 4408) with respect to dispensing requirements. The amended section now requires that dispensation may only occur "in good faith," and that a label must be affixed to any dispensed drug or medicine's container which identifies (1) date dispensed, (2) name of the patient, (3) last name of the person dispensing the drug or medicine, (4) directions for use, (5) proprietary name or names (or, if none, established name or names of the drug or medicine) (6) dosage and (7) quantity. The only exceptions to these requirements will be by specific regulation of the Department of Registration and Education.

# Surgical Grand Rounds

JOHN M. BEAL, M.D. AND JULIUS CONN, JR., M.D., CONTRIBUTING EDITORS

*Surgical Grand Rounds are held weekly on Tuesday, 5:00 P.M. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of November 4, 1980.*

## *Management of Testicular Tumors*

**Dr. John Bockrath:** A 25-year-old white man presented with a right testicular mass of approximately four months' duration. The patient had first noticed mild tenderness in the right scrotum. The tenderness and mass had persisted following trivial trauma.

Physical examination was unremarkable except for the presence of a firm 1cm.x2cm. mass in the lower pole of the right testicle. Laboratory evaluation at the time of admission revealed a hemoglobin of 15.2gm., hematocrit of 43.2% and WBC of 6600. Chest X-ray, urinalysis and intravenous pyelogram were normal. Beta human chorionic gonadotropin (HCG) and alpha fetoprotein were within normal limits.

Following this evaluation the patient was operated upon. The mass was explored via a right inguinal incision. Frozen section examination was anaplastic seminoma. A right radical orchiectomy was then performed. The patient recovered uneventfully. A lymphangiogram which was performed post-operatively showed multiple positive nodes in the retroperitoneum. The patient was considered to be Stage II. He is now being treated with radiation therapy to the retroperitoneal and mediastinal areas.

The second patient was a 19-year-old male who noticed a change of sensation in the left testis which persisted for some period of time. There was associated pain and swelling, but a specific incident of trauma was not recalled by the patient.

He was seen by a local college doctor, who referred him to a urologist. The patient underwent a left radical orchiectomy prior to being transferred to this hospital. Pathologic diagnosis was embryonal cell carcinoma. On transfer, the patient was found to have a normal chest X-ray and IVP. His hemoglobin was 16.3gm., hematocrit 46.9%; beta HCG was within normal limits, as was alpha fetoprotein. Both were determined after orchiectomy. The beta HCG determination prior to the orchiectomy was normal, but we do not have any information regarding the pre-operative alpha fetoprotein.

Physical examination in the hospital was unremarkable except for the surgically absent right testicle. Ultrasound evaluation of the retroperitoneum was normal. Computerized axial tomography of the retroperitoneum was within normal limits. Subsequently, he underwent a retroperitoneal lymph node dissection. The 18 lymph nodes which were obtained during this procedure were found to be free of metastatic carcinoma.

**Dr. Hector Battifora:** Most tumors of the testicles are malignant and of germ cell origin. The only nongermlinal tumor that we observe with some regularity in this region is malignant lymphoma, mostly in elderly men.

I will discuss briefly the most common germ cell tumors of the testicles. I should point out, however, that most of my comments apply equally well to extragonadal tumors. General sur-



geons should remember that they are more likely to encounter germ cell tumors of extragonadal origin. The most common sites for these are the retroperitoneum and mediastinum.

**TABLE 1**

**Classification of Testicular Neoplasms (after Dixon and Moore)**

- 1) seminoma, pure
- 2) embryonal carcinoma, pure or with seminoma
- 3) teratoma, pure or with seminoma
- 4) teratoma, with either embryonal carcinoma or choriocarcinoma, and with or without seminoma
- 5) choriocarcinoma, pure or with seminoma or embryonal carcinoma, or both

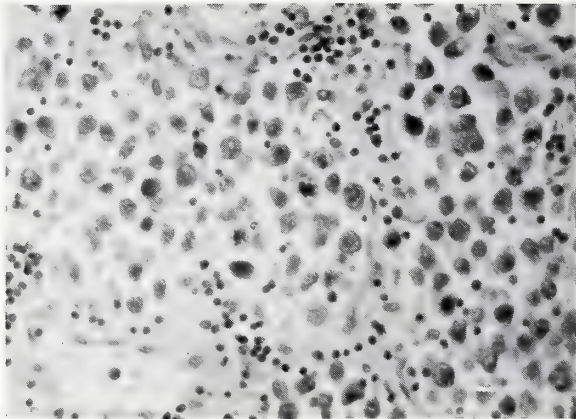
Germ cell tumors are thought to originate from totipotent cells capable of differentiating along many lines. Four major histological types are recognized in these tumors. These are seminoma, embryonal carcinoma, teratoma and choriocarcinoma. There may be only the one type present in a given tumor, but more commonly we see admixtures of two or more types. The classification of Dixon and Moore takes into account the tendency for testicular tumor to be heterogeneous. Their classification (Table 1) is useful in that it has prognostic significance with pure seminoma having the best prognosis and choriocarcinoma, the worst.

**Seminoma**

These are usually homogeneous tumors composed of large cells with clear abundant cytoplasm divided into clusters by thin fibrous septa with a prominent lymphocytic infiltrate. Modern classifications subdivide it into classic, anaplastic and spermatocytic. The anaplastic variant, which has the worst prognosis, is identified mostly by its higher mitotic rate. One of the cases discussed today is an example of anaplastic seminoma. (Figure 1) Spermatocytic seminoma, seen almost exclusively in the elderly, is extremely well differentiated and does not metastasize.

**Embryonal Carcinoma**

These are grossly hemorrhagic and necrotic and histologically have large anaplastic tumor cells. Formation of structures resembling primitive embryos may be observed. A special form, found primarily in children, is called infantile type. It has a characteristic histological pattern reminiscent of the endodermal sinus of rodent placenta and, because of this, is also known as endodermal sinus tumor. The second patient discussed today



**Figure 1.**  
Anaplastic seminoma is composed of large cells divided into clusters by their fibrous septa (Case 1).

is an example of embryonal carcinoma as depicted in Figure 2.

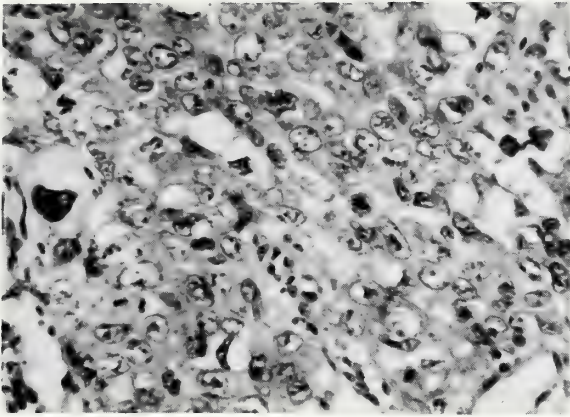
**Teratoma**

Grossly, these are very heterogeneous tumors which may be subdivided into mature or immature types. Ordinarily, cells corresponding to all the layers of the embryo are recognizable in various stages of differentiation.

**Choriocarcinoma**

Presence of this histological type always worsens the prognosis. Because of its tendency to invade vessels, hemorrhage is grossly quite evident around foci of choriocarcinoma. This tumor is characterized histologically by presence of cytotrophoblast and syncytiotrophoblast. The presence of multinucleated syncytiotrophoblast alone is insufficient to establish the diagnosis. This is important to remember because this may be seen in pure seminoma, for example, and it does not alter the prognosis.

**Dr. Earl Wendel:** I want to present basic points that are important for people who are not urologists, as well as some of the surgical aspects of the disease. Testicular cancer is very rare among Black and Oriental persons. There are a number of findings that suggest genetic factors in its etiology. The incidence in Uganda is 0.09 per 100,000 males. The incidence in England and in the United States is 2.5 per 100,000 white males. In the Black population that has moved to the United States, the incidence does not increase. Thus, environmental factors do not seem to play a part. Testicular cancer accounts for 1% of all the neoplasms in males in this country. However,



**Figure 2.**

Characteristic appearance of embryonal carcinoma was demonstrated by Case 2.

it is the most common cancer in the males who are essentially in their highest reproductive period, between 15 and 35 years of age, and is the third leading cause of death in these men.

There are about 450 deaths per year from testicular cancer in this country. There are a number of factors that suggest that it has some genetic determinants. One is that you can produce it very nicely in inbred strains of mice. There are many reports of familial incidence and incidence in monozygotic twins and increased incidences in heterozygous twins and siblings. In addition, now that some of the chromosome patterns have been studied, it has been found, at least in human teratocarcinoma, that there is a significant difference in some of the HLA aspects. The HLA-DW7 is significantly different in men with teratocarcinoma versus men without it. In addition, there is some autosomal chromosome difference in men with testis tumors. In the human testis tumors studied, all have numerical and structural changes involving chromosome No. 1 so there may well be significant genetic determinants in this disease. Testis tumors present in reproductive age males so that hormonal differences seem significant as far as its development. Decade to decade there does not seem to be much change in the pattern or rate of incidence.

One other thing which is related to the development of testis tumors is undescended testes. There is a significant incidence in cryptorchid testes. In a group of army recruits who were studied, the incidence of cryptorchism is just what it is in the adult population, .28% or three in 1,000 have an undescended testis. In a combined series in which about 13,000 men with testis tumors

were studied, the incidence, conversely, of cryptorchism was about 10%. If you put these statistics together, there is an increased incidence of 20-40 times normal of men with cryptorchism developing testes carcinoma. Abdominal testes have a higher incidence than inguinal testes, and, supposedly, about one in 20 abdominal testes will eventually develop a malignancy. However, if you look at this group of men with cryptorchism, they also have an increased incidence of carcinoma in the normally descended contralateral testis, and in the men with cryptorchid testis who develop carcinoma, 20% are actually in the descended testis. This information carries over to fertility statistics, as well. Many of the men with an undescended testis are infertile which has been documented to be due not only to the cryptorchid being abnormal, but the contralateral descended testis is abnormal histologically  $\frac{1}{3}$  or  $\frac{1}{4}$  of the time.

There is always a question about what to do with an undescended testis. Many of these cases present with their testes tumors later in life than do the men with descended testes and they present at a later stage. Instead of presenting as a localized A disease, they present as Stage B or C. A man with carcinoma in a descended scrotal testis will have metastasis out of the testis in the retroperitoneum in about  $\frac{1}{3}$  of the cases. Men with undescended testes who present with carcinoma actually have advanced stage disease in about  $\frac{2}{3}$  of the cases. Unfortunately, doing an orchiopexy does not change the incidence of carcinoma. If you bring the testicle down before the age of ten, it probably doesn't change the incidence of subsequent development of malignancy. After doing an orchiopexy you still must examine that patient, at least, on a yearly basis. There may be a slight benefit in doing an orchiopexy before the age of five or six, but that is not solid information.

### Diagnosis

These patients present with a mass or with pain and a mass, or, occasionally, they present with symptoms of metastases. When we see an enlarged right testicle, as compared with a normal testicle, we examine the patient carefully. They usually have a firm nodule in the testis that may involve the epididymis. It is usually painless. There is usually some normal testis surrounding the mass. If you have doubt, you should not send the patient away. Have your associate examine him. If there is still doubt, you should explore this surgically. The surgical exploration is never through the scrotum, but always through an inguinal incision.

There are a variety of unproven, unreliable di-



agnostic methods in study of testicular tumors. Ultrasound is not reliable. Radionuclide scanning of the scrotum is not reliable. There are some interesting studies in the Scandinavian literature of microvascular studies of the spermatic arteries. They are interesting but not diagnostic. The only way to diagnose these tumors is with surgical exploration. When a patient with a suspected testis tumor is examined, do not just look at that area; examine the supraclavicular lymph nodes and check for gynecomastia, which is a very disturbing finding. Incidentally, a patient can present with gynecomastia as the initial complaint. Examine the abdomen for organomegaly. Prior to exploring the testicle by the inguinal approach, draw blood for tumor markers. These are not for diagnosis but for follow-up and staging of these patients. Do not delay the surgical treatment. We do a radical or total orchiectomy through an inguinal incision and remove the testicle, the epididymus, tunica vaginalis, and the spermatic cord up to the internal inguinal ring. At that point, we put a permanent suture on the vascular structures at the abdominal wall as a marker for purposes of locating it when we do a retroperitoneal lymphadenectomy.

**Recommended Incision**

There are several reasons for an inguinal incision. First, it offers an easy access to all the intrascrotal structures and the spermatic cord (which, in some cases is invaded by tumor to the abdominal wall) can be excised. Prior to mobilizing the testicle out of the scrotum, the cord is cross-clamped with a rubber-shod or non-crushing clamp to control the vascular structures before inspecting and mobilizing the mass. The inguinal approach also minimized the chance of seeding the wound. In the series done through the scrotum, the development of tumor in scrotal incision was 24%. In addition, inguinal lymph nodes are contaminated, which complicates treatment. A recent series of contaminated orchiectomies showed that 19% of those done through the scrotum resulted in local recurrence. If this occurs, you are faced with the possibility of performing a hemi-scrotectomy and groin resection, as well as retroperitoneal lymphadenectomies. Once you bring the testis and cord structure through an inguinal approach, you remove the tunica vaginalis and inspect the testicle, making sure that you are dealing with tumor. If there is doubt, it is probably safe to do a frozen section biopsy.

This is standard staging for testes tumors but, like any staging, the classification does not satisfy all persons.

<b>Table 2</b> <b>A Simple Standard Staging</b>	
Stage A:	Limited to testis
Stage B:	Metastasis to retroperitoneum
B1:	Microscopic metastases to 5 or fewer lymph nodes
B2:	Metastases to more than 5 nodes, any node greater than 2cm. or any extracapsular spread
B3:	Massive, palpable retroperitoneal metastases
Stage C:	Metastases beyond retroperitoneum, positive tumor markers after lymphadenectomy

Testes tumors spread in a step-wise fashion to the retroperitoneal lymph nodes so we focus on the retroperitoneum. Unfortunately, it is a very difficult area to evaluate. We do either conventional or computed tomography of the lungs which are better at demonstrating a small metastasis than routine chest X-rays. Then, we do an IVP to see if there is deviation of the ureters as well as to make sure that the kidney is not massively involved. Next, we are faced with evaluating the retroperitoneum. The problem is differentiating micrometastases, that is, Stage A from Stage B1 or B2 disease. Small metastases are difficult to define. This is responsible for the 20% error rate in staging. There is a minimum 20% error rate with lymphangiograms, CT scans and ultrasound. The false-negative rate, calling a testis tumor Stage A, or limited to the testis when it is really metastatic to the retroperitoneum, is 15-30%. The false-positive rate is almost the same as this. Ultrasound and CT scan are excellent for large nodes or for bulky metastases. A node has to be about 1.5cm. to be defined by ultrasound. Lymphangiograms are done primarily for seminomas since patients with this tumor are generally not subjected to lymphadenectomy. They are usually treated with radiation therapy. Lymphangiograms are excellent for the radiotherapist in outlining fields of therapy for these patients. Lymphangiography has not generally been used to stage NSGCT (non-seminomatous germ cell tumors). Either ultrasound or CT scan is used to define markedly enlarged nodes. When all studies are negative, we still explore the retroperitoneum in non-seminomatous cell tumors.

The second patient was referred for a retroperitoneal lymphadenectomy. Node dissection is the cornerstone of treatment in patients with Stage I and II NSGCT since it is therapeutic and stages the disease for further therapy, such as chemotherapy. In the original Army series by Dr. Patton, it was demonstrated that over 50%, 65 out of

125 patients with positive retroperitoneal nodes, survived five years or longer after lymphadenectomy alone. That is better than 50% survival in metastatic embryonal carcinoma, without additional treatment. In a similar group of patients who were treated with radiotherapy alone, only 13% survived five years. Three to five years survival, by the way, is a cure in this disease. Recurrence of testis carcinoma after this time is extremely unlikely.

### Typical Surgical Procedures

The procedure that is actually done varies with the institution, the physician, and with his philosophy and training. Several centers utilize a thoracoabdominal approach with a bilateral supra-hilar resection, that is above the renal hilus, including the ipsilateral adrenal gland, and the perirenal tissue to the crux of the diaphragm. Some surgeons divide the crura of the diaphragm and include the posterior mediastinum. Those procedures have not been proven to increase patient survival.

Most centers do a transabdominal procedure, as we usually do, and dissect either unilaterally or bilaterally below the renal hilus. We remove all of the lymphatic tissue and connective tissue along the great vessels, including the renal arteries, the aorta, the vena cava, and the iliacs. The superior border of the dissection is the superior mesenteric artery with the lateral borders defined by the ureters.

The inferior border is the proximal iliac artery on the contralateral side and the distal external iliac artery on the ipsilateral side. The ipsilateral gonadal vessels and, occasionally, the contralateral vessels, are ligated and included in the specimen. The inferior mesenteric artery is sacrificed.

Although there are complications in the node dissection, they are fairly low and occur mainly in Stage B3 with bulky disease in the abdomen, or Stage C with metastatic disease. In Stage A and B disease, the complications are less than 5%. The major complications are primarily superficial wound dehiscence and the minor complications are primarily superficial wound infections. In patients with massive abdominal involvement, the major complication rate is 17% which is fairly acceptable. A major reason not to do suprahilar dissection is that patients are essentially sterile after this procedure. Staying below the renal vessels and sparing the L1 and L2 sympathetic ganglia allows the majority of these patients to have emission, ejaculation and potency. Going above the renal vessels to the diaphragm prevents the majority of them from having emission; that is, no sperm enter the posterior urethra

before ejaculation. They will have an erection but they will have a dry ejaculation. Only a small percentage of these patients will be fertile. Lymphadenectomy is very effective. Tumor recurrence in the retroperitoneum, that is, failure after a lymphadenectomy, is about 1%. Almost all of the patients who develop recurrent disease have pulmonary metastases.

### Recurrence

How do we manage these recurrent tumors? Radiation therapy is given for a seminoma with several exceptions. One is massive disseminated disease which should be treated with chemotherapy and reductive surgical procedures. Another possible exception, as Dr. Battifora mentioned, is anaplastic seminoma or seminomas with positive tumor markers. These patients may be considered for chemotherapy. Non-seminoma (NSGCT) is treated by node dissection. If the nodes are negative, the patients need no other treatment. They are watched for three to five years. If they remain free of tumor, they do not need any other treatment. Patients with positive nodes are treated with chemotherapy and followed closely. Good results are obtained with treatment due partly to lymphadenectomy, partly to radiation therapy and partly to recent improvements in chemotherapy.

In testicular tumors, alpha fetoprotein is elevated in patients with teratocarcinoma and embryonal carcinoma. About 70% of patients with embryonal carcinoma have elevated AFP which is synthesized by the fetal yolk sac, liver and GI tract. It is a major serum protein in the fetus up to about one year of age. It then disappears. An adult has a serum level below 16hg/nl as determined by radioimmune assay. Levels above 20 are essentially abnormal. Beta HCG was studied first in women with choriocarcinoma. It is routinely elevated during pregnancy. There are two subunits, a beta subunit which carries the specific immunological and biological determinants and the alpha chain which is similar to that of human LH. There is a very extensive structural homology between normal male LH and beta HCG, and, because of this similarity, specific antibodies are needed to differentiate between them. If a high level of LH exists in these patients, you may need to suppress endogenous LH with testosterone to determine if the beta HCG is tumor specific. The sensitivity of the beta HCG analysis is about 1mg. Anything above 5 is considered abnormal. It is elevated in about 40%-60% of patients with non-seminomatous metastases. Teratoma has AFP, embryonal carcinoma has AFP, and teratocarcinoma, of course, has AFP. Choriocarcinoma



has elevated levels of beta HCG in 100% of cases. Positive tumor markers are significant findings. One of the major improvements in treating testicular tumors during the past five years has been the ability to determine tumor markers at low levels.

## CHEMOTHERAPY

In 1958, Li, working at the National Cancer Institute, reported a dramatic effect of methotrexate on gestational choriocarcinoma. In 1960, he reported a successful chemotherapy regimen in testicular tumors: a combination of actinomycin-D, chlorambocil and methetrexate with a 50%-70% response and 10%-20% complete remission. The finding of a synergistic effect of vinblastine and bleomycin resulted in the following proposed regimens.

- VAB I Vinblastine, actinomycin-D and bleomycin
- VAB II Vinblastine, cisplatinum and bleomycin
- VAB III Vinblastine, actinomycin-D, cisplatinum, bleomycin, cyclophosphomide

These regimens have resulted in a two year survival rate of 70% in disseminated Stage III patients. At present, the major treatment regimens are VAB III and VBP (Vinblastine, bleomycin, cisplatinum). Both are effective with complete remissions in 60%-70% of patients, with another 10%-15% made disease-free by surgical removal of the residual tumor.

**Dr. James Hines:** We frequently hear reports of four and five months' patient or physician delay in making the diagnosis of testicular tumor. Is it reluctance of the patients to see a doctor or failure of the doctor to pursue the diagnosis?

**Dr. Earl Wendel:** It is documented in this disease that the treatment lag is somewhere between three and six months after the onset of symptoms. First, the patient will defer seeing a physician for several months, possibly because he is afraid of tumor, possibly because he thinks he has a venereal disease, or he hopes the mass will go away. Secondly, when he is seen by the physician, there is a lag in treatment because the mass is thought to be epididymitis or a benign lump. The physician will treat the patient another month or two before surgical treatment is recommended. Ideally, men should examine their genitals on a regular basis just as women examine their breasts.

# Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg cildinium Br.

Please consult complete prescribing information, a summary of which follows:

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or cildinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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Artist's concept of myoelectrical slow waves of the colon which seem to determine the frequency of colonic motor activity.

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**References:** 1. Sullivan MA, Cohen S, Snape WJ. *N Engl J Med* 298:878-883, Apr 20, 1978.  
2. Snape WJ et al. *Gastroenterology* 72: 583-587, Mar 1977.

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“The penalty for wise men who refuse to become involved in the affairs of government is to live under the government of unwise men.”

Sir Edmund Burke

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(ibuprofen)





# compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients.

In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups...

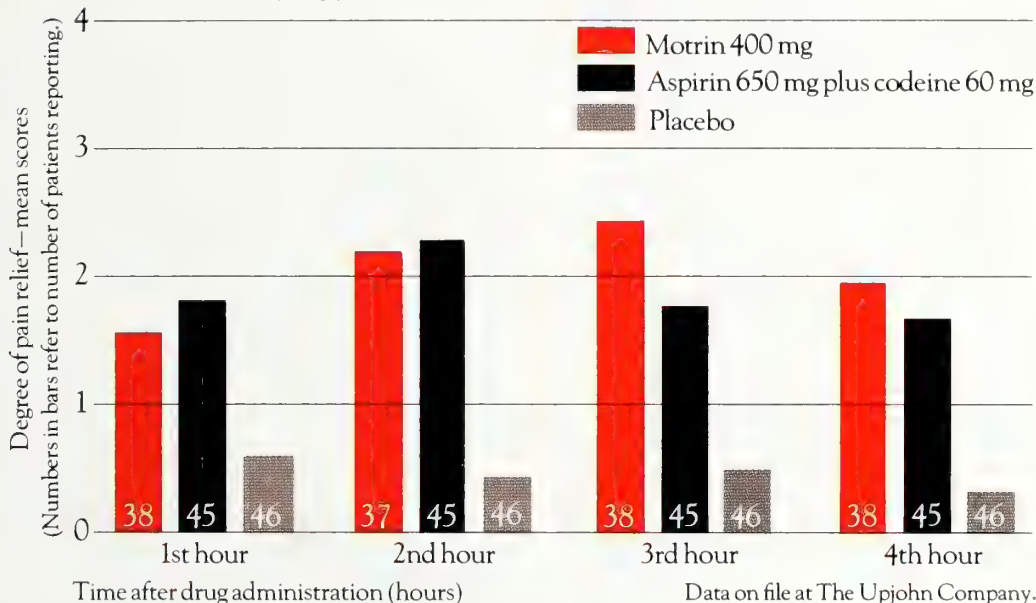
with *Motrin* being significantly more effective ( $p = 0.03$ ) at the three-hour interval.

Active treatment was significantly more effective ( $p < 0.0001$ ) than placebo at all time intervals.

## Comparison of pain relief

### Motrin vs aspirin-codeine combination

4 = Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief



One tablet q4-6h prn

For relief of mild to moderate pain:

**Motrin<sup>®</sup> 400mg** TABLETS  
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- Not a narcotic • Not addictive • Not habit forming • Nonscheduled
- Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

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**Motrin®** (ibuprofen)

## now proved an effective analgesic for mild to moderate pain

**Motrin® Tablets** (ibuprofen, Upjohn)

**Indications and Usage:** Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

**Contraindications:** Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

**Warnings:** Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

**Precautions:** Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

**Drug interactions.** *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

**Pregnancy and nursing mothers:** Motrin should not be taken during pregnancy nor by nursing mothers.

### Adverse Reactions

#### ***Incidence greater than 1%***

**Gastrointestinal:** The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,\* epigastric pain,\* heartburn,\* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,\* headache, nervousness. **Dermatologic:** Rash\* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

\*Incidence 3% to 9%.

#### ***Incidence less than 1 in 100***

**Gastrointestinal:** Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

#### ***Causal relationship unknown***

**Gastrointestinal:** Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

**Overdosage:** In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

**Dosage and Administration:** Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

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MED B-4-S

## Clinics for Crippled Children Listed for March

Forty-five clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 31 general clinics, 11 cardiac clinics, one for children with neurological problems, one for children with myelodysplasia and one for children with scoliosis. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- 1 Peoria Myelodysplasia - St. Francis Med. Ctr.
- 2 Park Ridge General - PM - Lutheran General Hospital
- 2 Park Ridge Cardiac - AM - Lutheran General Hospital
- 2 Wheaton - Marianjoy Rehabilitation Hosp.
- 3 Carmi - Carmi Township Hospital
- 4 Springfield General - Memorial Med. Bldg.
- 4 Sterling - Community General Hospital
- 4 Hinsdale - Hinsdale Sanitarium
- 4 Lake County Cardiac - Victory Mem. Hosp.
- 5 Division Cardiac - U. of I. at the Medical Center
- 8 Peoria Cardiac - St. Francis Med. Center
- 8 Maywood (Orth/Ped/Neuro) - Loyola Medical Center
- 8 Chicago Heights Cardiac - St. James Hosp.
- 9 Carrollton - Boyd Memorial Hospital
- 9 East St. Louis - Community Hospital
- 9 Peoria General - St. Francis Med. Center
- 10 Rockford - St. Anthony Hospital
- 10 Champaign - Urbana (no Peds) - McKinley Health Service Center
- 10 Chicago Heights General - St. James Hosp.
- 10 Joliet - St. Joseph's Hospital
- 11 West Frankfort - United Mine Worker's of America - Union Hospital
- 11 Macomb - McDonough Health Department
- 11 Effingham - St. Anthony Memorial Hospital
- 11 Aurora Cardiac - Mercy Center for Health Care Services
- 11 Kankakee General - St. Mary's Hospital
- 12 Hinsdale Scoliosis - Hinsdale Sanitarium
- 15 Maywood (Ortho/Ped) - Loyola Med. Center
- 16 Rock Island General and CP - Moline Public Hospital
- 16 Decatur - Decatur Memorial Hospital
- 16 Belleville - St. Elizabeth Hospital
- 17 Springfield Ped-Neuro - Memorial Med. Bldg.
- 17 Aurora General - Mercy Center for Health Care Services
- 17 Evergreen Park - Little Company of Mary Hospital
- 18 Centralia - St. Mary's Hospital
- 18 Elmhurst Cardiac - Memorial Hospital of DuPage County
- 19 Kankakee Cardiac - St. Mary's Hospital
- 22 Peoria Cardiac - St. Francis Medical Center
- 22 Chicago Heights Cardiac - St. James Hosp.
- 23 Peoria General - St. Francis Medical Center
- 24 Chicago Heights General - St. James Hosp.
- 25 Champaign Children's Home - Champaign
- 25 Exceptional Care & Training Ctr. - Sterling
- 29 Peoria Cardiac - St. Francis Med. Center
- 30 Alton - Alton Memorial Hospital
- 31 Elgin - Sherman Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

# Viewbox

(Continued from page 85)

## Diagnosis: (3) Hemangioma

Plain film examination of the chest demonstrated a heart of normal size and no evidence of metastases or CHF. Examination of the abdomen by plain film, IVP, ultrasound, radionuclide scan and angiography demonstrate a mass within the confines of the liver including much of the right lobe and the medial segment of the left lobe. Both kidneys appear normal and occupy normal positions within the abdomen, ruling out entities such as neuroblastoma, Wilms' tumor, hydronephrosis, and multicystic kidney. The ultrasound scan suggests a mass such as a hepatoma. CT was done but did not add any significant information over that obtained by ultrasound and the liver-spleen scan.

The appearance of the angiogram included enlarged feeding vessels to the liver, normal appearing arteries within the liver and pooling of contrast material in sinusoidal spaces for a prolonged period of time. These findings suggest the diagnosis of a vascular lesion such as hemangioendothelioma or hemangioma. Early venous drainage which may be seen frequently in hemangioendothelioma is not present. Neovascularity, encased vessels and parenchymal staining, as would be seen in hepatoma or hepatoblastoma, are not present.

Open biopsy was obtained to confirm the preoperative diagnosis of hemangioma. Because the liver was so extensively involved by the lesion, resection was not attempted.

Liver neoplasms are rare in infants and children but are an important subgroup of abdominal tumors in this age group. A limited review of the English language literature concerning liver neoplasms reveals some disagreement among authors as to the relative frequency of the various liver neoplasms. These differences can be explained in part by the small number of cases in most reports and by differences in the pathologic classification of the various entities.<sup>1,3-5</sup> One can best appreciate

the difficulty in acquiring sufficient data for a meaningful analysis by inspecting the results of *The 1974 Liver Tumor Survey* by Foster and Berman.<sup>2</sup> In this survey, which encompassed the experience of 98 hospitals over a 15 year period, only 72 cases of primary epithelial liver cancer in children were collected and subjected to a classification using unified pathologic criteria.

Primary liver neoplasms appear to be the third most common abdominal neoplasm after neuroblastoma and Wilms' tumor. However, as in the adult, metastases outnumber all primary benign and malignant liver tumors.<sup>4</sup> While these neoplasms are distributed throughout the entire pediatric age range, they are most commonly observed within the first two to three years of life.<sup>9</sup> Hepatoma and hepatoblastoma are the most common primary malignant neoplasms, while hemangioma, hemangioendothelioma and hamartoma are the most common benign neoplasms encountered. These five entities in aggregate far outnumber any other primary neoplasms reported.<sup>6</sup>

Liver neoplasms, whether benign or malignant, most commonly present as an upper abdominal mass or as enlargement of the abdomen observed by the parents or discovered by the pediatrician as an incidental finding during a physical examination. In the case of malignant tumor, symptoms include pain, fever, weight loss, vomiting and diarrhea. These symptoms are infrequent. Jaundice is uncommon, except as a late finding. A child with a benign hemangiomatous lesion may present with congestive heart failure due to a left to right shunt, but children with other benign liver tumors rarely have any symptoms directly related to their tumor. Occasionally those children harboring a hemangiomatous lesion will also have cutaneous hemangiomas and a coagulopathy may be demonstrated with appropriate laboratory studies (Kasabach-Merritt syndrome). Routine laboratory tests are frequently normal or only borderline abnormal, even in the presence of a malignant liver tumor.<sup>3,6</sup>

Because the results of clinical evaluation and laboratory studies are frequently nonspecific, the various imaging modalities play an important role in the evaluation of children suspected of harboring a liver tumor. Plain film examination of the chest and abdomen will demonstrate the presence of a soft tissue mass which can be often localized to the liver. Calcification may also be visualized but is uncommon in liver tumors,<sup>7</sup> and is not helpful in predicting the histology of the underlying neoplasm. The presence or absence of metastases in the lungs or adjacent skeletal structures may, however, be a valuable clue in the



differential diagnosis. Congestive heart failure suggests the possibility of a hemangiomatous lesion with an A-V shunt.

Excretory urography is useful in excluding renal pathology and some authors advocate injecting the contrast material into a lower extremity vein in order to opacify the inferior vena cava. Useful information concerning displacement, occlusion or invasion of the vena cava by intra-abdominal process can be obtained in this manner.<sup>7</sup> Static hepatic scintiscanning can demonstrate intrahepatic masses and frequently differentiates single from multiple lesions, but malignant and benign lesions cannot be differentiated. A radionuclide flow study, however, may be very helpful in separating hemangiomatous lesions from other solid or cystic tumors. Very rapid visualization of the abnormal region of the liver during the arterial phase followed by slow clearing is typical of a hemangioma.<sup>7,8</sup>

Ultrasound and computed tomography can also be very useful in evaluating liver masses. Ultrasound can reliably differentiate solid from cystic lesions and occasionally a pattern of multiple small anechoic areas, which suggest a vascular malformation, may be detected in the liver. The presence or absence of renal or adrenal abnormalities may also be readily detected. Involvement of one or both lobes of the liver can be ascertained. C.T. on the other hand provides similar information. However, because of motion and the frequent lack of distinct fat planes in the infant and very young child, it may not be possible to accurately localize a lesion within or outside the liver. This modality also requires injection of contrast agents and use of sedatives to control motion. These steps take C.T. out of the realm of non-invasive studies. Ultrasound obviously does not depend on ionizing radiation, nor does it require contrast agents. For these reasons, ultrasound should be used early in the evaluation of the patients, perhaps even before excretory urography and nuclear imaging studies are undertaken.

Angiography represents the final imaging procedure which can be undertaken prior to surgical intervention. This procedure is most helpful in providing the surgeon with valuable anatomic information concerning the vascular supply of the liver, including the presence of anomalous arteries which may complicate or simplify surgery. Neoplastic involvement of major venous structures which would preclude an attempt at resection can be identified. In order to maximize the amount of information gained, selective injections must be performed. It should be remem-

bered, though, that the angiographic appearance of the majority of lesions will be nonspecific and a histologic diagnosis cannot be made with certainty.

In some instances, however, findings quite characteristic of hemangioma or hemangioendothelioma will be seen. These include pooling of contrast agents in sinusoids for very long periods of time, enlargement of the aorta proximal to the point of origin of the vessel feeding the vascular malformation with a sudden change to a smaller caliber distally, and a lack of distinct neovascularity within the liver.<sup>1</sup>

Early filling of hepatic veins may also be seen. When these angiographic findings are present, combined with other suggestive clinical, laboratory and imaging findings, a presumptive diagnosis of vascular malformation can be made without proceeding to biopsy.<sup>1,10</sup> If a young child presents with congestive heart failure and is found to have a liver mass without known antecedent heart disease, the diagnosis of hemangioma with A-V shunting should be suspected. In many instances these patients can be treated expectantly, since the vascular malformation may involute as the child matures. In those instances in which a complication such as congestive heart failure, rupture or a consumptive coagulopathy is present, steroid therapy, radiation therapy, embolotherapy or surgery may be undertaken. ◀

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# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

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*Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**BENTON:** Family Physician wanted to join growing medical staff associated with a modern, 113-bed community hospital in southern Illinois. Guarantee and other benefits. Excellent recreational and university facilities nearby. CONTACT: Ann Acton, Franklin Hospital, Benton, 62812, (618) 439-3161, Ext. 367/368. (4)

**CARBONDALE:** Family or General Practice. Community Health Center in southern Illinois, 10 miles from SIU-Carbondale. Affiliation with Black Lung Clinic Programs possible. Established practice with multi-disciplinary staff. Position available immediately. Salary, fringe benefits are very competitive; malpractice insurance and vacation also provided. CONTACT: George M. O'Neill, Shawnee Health Service & Development Corporation, 103 S. Washington, #210, Carbondale 62901 (618-457-3351). (4)

**CENTRAL ILLINOIS:** Two community hospitals within twenty minutes of each other are currently seeking a urologist. Possible partnership with consulting urologist now servicing this area. More patients than one urologist can handle. Area is known for recreational activities. Contact: Search Committee, P.O. Box 430, Pana, 62557. (217-562-2131 x271) (4)

**CLIFTON:** Service Area, 8,500—Immediate opening for family practitioner in rural setting. First year: guarantee, office space/staffing provided. Seventy miles south of Chicago on interstate highway. Excellent school system. Obstetrics or general internal medicine background helpful. CONTACT: George Rasmussen, Central Community Hospital, Clifton 60927. AC 815-694-2392. (10)

**CLINTON, IA:** Internist (with/without subspecialty), Surgeon, OB-GYN, and ENT physicians are needed in Clinton. Multi-specialty group serving large part of Western Illinois. Excellent opportunity for quality care, professional interaction with friendly colleagues and financial security. Contact Dr. Daniel J. Baxter, collect: 319-243-4600 days or 319-242-6451 nights. (2)

**FAIRBURY:** Family practice physician—Excellent opportunity to join General Practice Physician planning retirement in two years. Cross coverage is available in this thriving rural practice. Fairbury Hospital, a 112-bed JCAH accredited hospital, offers income guarantees and other financial assistance. Contact: Kate H. Dickey, Director, Physician Recruitment, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739. (815-692-2346 x215) (4)

**GALESBURG:** Population 35,305. Seat of Knox County, pop. 61,300. An attractive college community 180 miles from Chicago. Near Peoria, Quad-Cities. Diversified industry and agribusiness. Full selection of educational, cultural and recreational activities. For information on practice opportunities, CONTACT: David D. Fleming, Vice-President, Galesburg Cottage Hospital, 695 N. Kellogg St., Galesburg 61401. 309/343-8131. (4)

**GENESEO:** Population 8,000, trade area - 29,000. Rich farming area. Downtown office fully equipped. Hospital - ultra modern. 25 miles east of quad cities - population 400,000. Quality community needing a quality physician. Contact: Mrs. A. W. Wellstein, 9 Maplewood, Geneseo 61254 (309-944-2530). (2)

**KEWANEE:** 108 bed community hospital involved in an expansion program is interested in recruiting family practitioners to our service area of 35,000 population. Several practice opportunities exist in group or solo practices. The population centers in the service area range from 15,000 in population and less. Contact Harold L. Bischoff, Kewanee Public Hospital, 719 Elliott Street, Kewanee 61443 (309) 853-3361. (4)



**LINCOLN:** 20 miles from Southern Illinois University School of Medicine in Springfield and halfway between St. Louis and Chicago on I55. Need two family practice physicians for growing practice. Office facilities available with 10 man medical group. Contact Mary Richter, 311 Eighth, Lincoln 62656. (217/732-9681). (4)

**MACOMB:** GP/FP 12 month contract. University health service. Outpatient clinic. No OB or surgery. Fringes include hospitalization, paid vacation, retirement, etc., approximately 11,000 students - city of 23,000. Competitive negotiable income. EOE/AA employer. Contact: C. E. Hughes, M.D., Dir, BEU Health Center, Western IL Univ. Macomb 61455 (309-833-2734) (2)

**MARSHALL:** Population 4,000. County seat of Clark County. Rural community. Comparatively new medical center with available space for 4 doctors. Presently have 2 doctors. Facility fully equipped with lab, x-ray, therapy, emergency room, pharmacy. Located 17 miles from three major hospitals. Have excellent school system and recreational facilities. CONTACT: Donald B. Smitley, Admin., 410 N. 2nd St., P.O. Box 219, Marshall 62441, 217-826-2358. (4)

**STERLING:** Progressive 16 physician multispecialty clinic seeks physicians in the following specialties: otolaryngology, general surgery, urology, and OB-GYN. Contact: David Benett, Clinic Manager, Sterling Rock Falls Clinic, Ltd., 101 E. Miller Road, Sterling, 61081 (815-625-4790). (2)

**SULLIVAN:** Population 5,000. New medical center with complete office and ancillary services available. Near universities and colleges. All recreational facilities nearby. CONTACT: Sandra Elder, 2 W. Adams, Sullivan 61951 (217) 728-8316 or (217) 728-4186. (4)

**WATSEKA:** Population service area 35,000. Opening for orthopedic surgeon. 23 physicians on staff at present. 85 miles from Chicago in rural area, 160 bed hospital. Within one hour drive of major universities. Very liberal financial package available first year. Contact Paul F. Wenz, 200 Fairman Street, Watseka 60970. (815) 432-5201. (4)

## PHYSICIAN

### (Part Time)

All-Steel, a leading steel office furniture manufacturing plant in Aurora, IL is seeking an Illinois licensed physician, preferably certified by the American Board of Family Practice to assume responsibilities to develop a comprehensive occupational medical dispensary. Physicians should have experience in trauma, treatment of fractures, and other traumatic injuries plus knowledge of OSHA, workers compensation and group insurance.

This is a part time position which offers flexible hours and excellent fringe benefits.

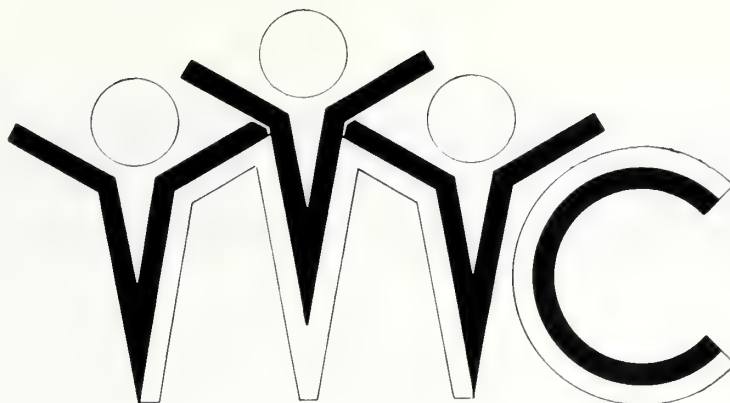
For consideration forward curriculum vitae, or call Colleen Reuland, 312/859-2600 ext. 406.

## THE ARMY NEEDS PHYSICIANS PART-TIME.

The Army Reserve offers you an excellent opportunity to serve your country as a physician and a commissioned officer in the Army Reserve Medical Corps. Your time commitment is flexible, so it can fit into your busy schedule. You will work on medical projects right in your community. In return, you will complement your career by working and consulting with top physicians during monthly Reserve meetings and medical conferences. You will enjoy the benefits of officer status, including a non-contributory retirement annuity when you retire from the Army Reserve, as well as funded continuing medical education programs. A small investment of your time is all it takes to make a valuable medical contribution to your community and country. For more information, simply call the number below.

## ARMY RESERVE. BE ALL YOU CAN BE.

Captain Richard W. Gustafson  
"COLLECT" (312) 926-3273



# Earn up to 20 Category I CME credit hours . . . Attend the 38th Annual Midwest Clinical Conference

The Chicago Medical Society will once again present the only meeting of its kind in the Midwest. This three-day conference will include courses programmed by 27 participating societies which will cover many of the latest discoveries and developments in medical science. Socio-economic courses of vital interest to your practice of medicine have been selected to round out the program.

## 38th ANNUAL MIDWEST CLINICAL CONFERENCE PARTICIPATING SOCIETIES

American Association of Medical Assistants  
American Diabetes Association  
Chicago Committee on Trauma American  
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Chicago Foundation for Medical Care  
Chicago Heart Association  
Chicago Neurological Society  
Chicago Ophthalmological Society  
Chicago Pathology Society  
Chicago Pediatric Society  
Chicago Psychoanalytic Society  
Chicago Radiological Society  
Chicago Surgical Society  
Chicago Urological Society  
Chicago Society of Industrial Medicine and  
Surgery  
Chicago Society of Internal Medicine  
Chicago Society of Plastic Surgery  
Chicago & Illinois Society of  
Anesthesiologists  
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Physicians  
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Emergency Physicians  
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**March 12-14, 1982**  
**Conrad Hilton Hotel**  
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**Category 1 Credit**

Send to: **The Chicago Medical Society**  
Division of Professional and  
Community Education  
515 N. Dearborn St.  
Chicago, IL 60610

Please send me information and registration materials for  
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Name \_\_\_\_\_

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# Guide to Continuing Medical Education

## MARCH

### Cannabinoids

**Conference on the Therapeutic Applications of Cannabinoids**  
**For:** MD's. Conference, March 29-30, Pheasant Run Resort.  
**Sponsors:** Illinois Cancer Council; U of Chicago; State of Illinois.  
**Contact:** Wayne Wiebel, State of Illinois-DDC, 300 N. State St., Suite 1500, Chicago 60610. **Phone:** 312/822-9860.

### Cardiology

**Arrhythmias and Cardiac Ischemia: Diagnosis and Management**  
**For:** GP's, FP's, Internists. Seminar, March 19-20, Marriott Hotel, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Dr. E., Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours; IACEP, 13 hours. **Contact:** Stephen Mattingly. **Phone:** 800/525-8651 x 123.

### Cardiovascular Disease

**Current Concepts in Therapeutic Drug Monitoring**  
**For:** GP's, FP's, Pathologists, Psychiatrists, Internists. Conference, March 25, St. Louis, MO. **Sponsor:** School of Medicine, St. Louis University, 1402 S. Grand, St. Louis, MO 63104. **Reg. deadline:** 3/18. **Fee:** \$45. **Reg. limit:** none. **Credit:** Category 1, 7 hours; AAFP Prescribed, 7 hours. **Contact:** John Grellner. **Phone:** 314/664-9800 x 127.

### Family Medicine

**Recognition & Management of Acquired Coagulation Disorders**  
**For:** MD's. Lecture, March 17, 7:00 p.m., Davenport, IA. **Speaker:** Lamont Gaston, MD. **Sponsor:** Mississippi Valley Regional Blood Bank, 3425 E. Locust St., Davenport, IA 52803. **Fee:** \$15. **Reg. limit:** 100. **Credit:** Category 1, 2 hours; AAFP Prescribed, 2 hours; AOA, 2 hours. **Contact:** Patricia Harrod. **Phone:** 319/359-5401.

### Family Practice

**Refresher Course for the Family Physician**  
**For:** FP's, GP's. Symposium, March 9-12, Iowa City, IA. **Sponsor:** U of Iowa, College of Medicine, CME, 285 Med Labs, Iowa City, IA 52242. **Reg. deadline:** none. **Fee:** \$250. **Reg. limit:** none. **Credit:** Category 1, 27 hours; AAFP Prescribed, 27 hours. **Contact:** R. M. Caplan, MD. **Phone:** 319/353-5763.

### Hypertension

**The Role of Beta Blockers in the Management of Essential Hypertension**  
**For:** MD's. Lecture, March 19, 8:00 a.m., Chicago. **Speaker:** Gerald Glick, MD. **Sponsor:** Grant Hospital, 550 West Webster, Chicago 60614. **Reg. deadline:** none. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Sharon Smith. **Phone:** 312/883-2112.

### Internal Medicine

**State & National Board Review, Clinical**  
**For:** MD's. Lecture, March 29 (6 days), Chicago. **Speaker:** Henry Jeffay, PhD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 90. **Credit:** Category 1, 56 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Internal Medicine

**State & National Board Review, Basic**  
**For:** MD's. Lecture, March 22 (6 1/2 days), Chicago. **Speaker:** Henry Jeffay, PhD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 90. **Credit:** Category 1, 62 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Nutrition

### Current Issues Facing the Food, Nutrition, and Health Professionals

**For:** MD's, Dietitians. Symposium, March 31, Ramada Inn-O'Hare, Chicago. **Sponsor:** CNA/IFT/ISMS Symposium, c/o Sandy Seligman, P. O. Box 87664, Chicago 60680. **Reg. deadline:** 3/19. **Fee:** \$30. **Reg. limit:** none. **Credit:** Category 2, 5 hours; ADA, 5 hours. **Phone:** 312/768-5000.

### Occupational Lung Disease

**International Conference on Occupational Lung Disease**  
**For:** MD's. Symposium, March 24-27, Hyatt Regency, Chicago. **Sponsor:** American College of Chest Physicians, 911 Busse Hwy., Park Ridge. **Reg. deadline:** none. **Fee:** \$200. **Reg. limit:** none. **Credit:** Category 1, 22 hours. **Contact:** Dale Braddy. **Phone:** 312/698-2200.

### Occupational Medicine

**Spring Seminar**  
**For:** MD's. Seminar, March 26-27, Hyatt Hotel, Oak Brook. **Sponsor:** Central States Occupational Medical Assn., c/o 119 Shabbona Dr., Park Forest 60466. **Fee:** \$75. **Reg. limit:** none. **Credit:** Category 1, 8 hours; AAFP Elective, 10 hours. **Contact:** Rita Packer.

### Ophthalmology

**6th Annual Ophthalmology Current Concepts Seminar '82**  
**For:** Ophthalmologists. Workshops, March 25-26, Madison, WI. **Sponsor:** U of WI-Extension, CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** \$155. **Reg. limit:** none. **Credit:** Category 1, 2 hours; AOA, TBA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

### Ophthalmology

**Grand Rounds**  
**For:** Ophthalmologists. Grand Rounds, Wednesdays, March 3, 10, 17, 24 & 31, 4:00 p.m., Chicago. **Sponsor:** Dept. of Ophthalmology, U of I, 1855 W. Taylor, Chicago 60612. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Jacob Wilensky, MD. **Phone:** 312/996-7030.

### Ophthalmology

**Symposium and Workshop on Laser Therapy of Glaucoma**  
**For:** Ophthalmologists. Symposium and Workshop, March 25-26, Chicago. **Sponsor:** Dept. of Ophthalmology, U of I, 1855 W. Taylor, Chicago 60612. **Fee:** \$400; \$200 (Symposium only). **Reg. limit:** Symposium—none; Workshop—32. **Credit:** Category 1, 12 hours. **Contact:** Jacob Wilensky, MD. **Phone:** 312/996-7030.

### Thoracic Surgery

**Non-Malignant Tumors of the Esophagus**  
**For:** MD's. Lecture, March 11, 6:30 p.m., Hyatt House, Oak Brook. **Sponsor:** Illinois Thoracic Surgical Society, c/o Raymond A. Dieter, Jr., MD, 454 Pennsylvania, Glen Ellyn. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Phone:** 312/790-1700.

### Treatment of Viral Illnesses

**For:** MD's. Lecture, March 5, Chicago. **Speaker:** Stanley Rabinowitz, MD. **Sponsor:** Grant Hospital, 550 W. Webster Ave., Chicago 60614. **Reg. deadline:** none. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Sharon Smith. **Phone:** 312/883-2112.

### Viral Illnesses

## APRIL

### Bowel Disease

**Functional Bowel Disease**  
**For:** MD's. Lecture, April 23, Chicago. **Speaker:** Marshall Sparberg, MD. **Sponsor:** Grant Hospital, 550 W. Webster Ave., Chicago 60614. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Sharon Smith. **Phone:** 312/883-2112.

### Cardiac Rehabilitation

**State of the Art—1982**  
**For:** MD's. Symposium, April 22-23, St. Louis, MO. **Sponsor:** St. Louis University, School of Medicine, 1402 S. Grand, St. Louis, MO 63104. **Reg. deadline:** 4/15. **Fee:** \$175. **Reg. limit:** 20. **Credit:** Category 1, 14 hours. **Contact:** John Grellner. **Phone:** 314/664-9800 X 127.

### Cardiovascular Diseases

**Symposium on Cardiology**  
**For:** MD's. Symposium, April 2, 16, 23, and 30, 11:00 a.m., Oak Park. **Sponsor:** Oak Park Hospital, 520 S. Maple Ave., Oak Park. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Charles Weigel, MD. **Phone:** 312/366-7870.

### Endocrinology

**Endocrinology & Diabetes**  
**For:** Internists. Course, April 28-30, Indianapolis, IN. **Sponsor:** American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. **Fee:** \$200, members; \$150, associates; \$265, non-members. **Reg. limit:** 200. **Credit:** Category 1. **Contact:** Maxine Topping. **Phone:** 215/243-1200.

### Family Medicine

**Clinical Medicine Update**  
**For:** FP's, GP's. Lecture, April 12, Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$375. **Reg. limit:** 100. **Credit:** Category 1, 41 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Medical Ethics

**Medical Ethics**  
**For:** MD's. Lecture, April 27, 6:30 p.m., Kankakee. **Sponsor:** Riverside Medical Center, 350 N. Wall St., Kankakee 60901. **Fee:** \$3. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Lisa Mitchell. **Phone:** 815/933-1671.

### Medicine

**Dermatology**  
**For:** Dermatologists. Symposium, April 23, Springfield. **Sponsor:** SIU School of Medicine, CME, P.O. Box 3926, Springfield 62708. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Ophthalmology

**Grand Rounds**  
**For:** Ophthalmologists. Grand Rounds, April 14, 21 and 28, 4:00 p.m., Chicago. **Sponsor:** Dept. of Ophthalmology, U of I, 1855 W. Taylor, Chicago 60612. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Jacob Wilensky, MD. **Phone:** 312/996-7030.

## Pathology

### Obstetric & Gynecologic Pathology

**For:** Pathologists. Workshop, April 19-23, Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison St., Chicago. **Fee:** TBA. **Reg. limit:** 50. **Credit:** Category 1, 28 hours. **Contact:** Marian Macdonald. **Phone:** 312/738-1336 x 188.

## Pathology

### Review in Immunohematology & Blood Banking

**For:** Pathologists. Workshop, April 19-23, Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison St., Chicago 60612. **Fee:** \$400-500. **Reg. limit:** 60. **Credit:** Category 1, 33 hours. **Contact:** Marian Macdonald. **Phone:** 312/738-1336 x 188.

## Pathology

### Clinical Immunology & Immunopathology

**For:** Pathologists, Technologists. Workshop, April 26-30, Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison St., Chicago 60612. **Fee:** \$500-600. **Reg. limit:** 50. **Credit:** Category 1, 30 hours. **Contact:** Marian Macdonald. **Phone:** 312/738-1336 x 188.

## Pathology

### Computer Technology as it Applies to the Medical Laboratory

**For:** Pathologists. Workshop, April 28-30, Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison St., Chicago 60612. **Fee:** \$360-450. **Reg. limit:** 60. **Credit:** Category 1, 19½ hours. **Contact:** Marian Macdonald. **Phone:** 312/738-1336 x 188.

## Pathology

### Specialty Review in Pathology/Anatomic

**For:** Pathologists. Lecture, April 12, Chicago. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Reg. limit:** 200. **Credit:** Category 1, 49 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Pathology

### Specialty Review in Pathology/Clinical

**For:** Pathologists. Lecture, April 19, Chicago. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Reg. limit:** 200. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Plastic & Reconstructive Surgery

### Primary Care of Facial Injuries

**For:** MD's. Symposium, April 16, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 7 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Anxiety & Depression

**For:** MD's. Symposium, April 20, 7:00 p.m., Centralia. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Radiology

### Radiologic Approaches to the Chest and Abdomen

**For:** Radiologists, Oncologists, Surgeons, Pulmonary Disease Specialists. Lecture/workshop, April 28-30, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** \$310. **Credit:** Category 1, 2 hours; ACR. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Surgery

### Breast and Endocrine Disease

**For:** Surgeons, Oncologists. Symposium, April 16-17, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** \$155. **Credit:** Category 1, 9 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Surgery

### Fiberoptic Colonoscopy

**For:** MD's. Lecture, April 28, Chicago. **Speaker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 40. **Credit:** Category 1, 15 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

### Specialty Review in Thoracic Surgery, Part II

**For:** General & Cardiothoracic Surgeons. Lecture, April 5, Chicago. **Speaker:** Sidney Levitsky, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 200. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

### Flexible Fiberoptic Sigmoidoscopy

**For:** Surgeons. Lecture, April 17, Chicago. **Speaker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$100. **Reg. limit:** 60. **Credit:** Category 1, 7 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgical Trauma

**For:** Surgeons. Case presentation, 2nd Friday of mo., 4:30-6:00 p.m., Chicago Athletic Association, Chicago. **Sponsor:** CITC Group. **Reg. deadline:** none. **Fee:** none. **Reg. limit:** none. **Credit:** pending. **Contact:** Peter Geis, MD. **Phone:** 312/531-3454.

## Urology

### Specialty Review in Urology

**For:** Urologists. Lecture, April 19, Chicago. **Speakers:** Drs. Thomas John and Irving Bush. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 200. **Credit:** Category 1, 53 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## MAY

## Anesthesiology

### Midwest Anesthesiology Conference

**For:** MD's. Lectures, May 6-8, Chicago Marriott Hotel. **Sponsor:** Illinois Society of Anesthesiologists, c/o Michael Reese Hospital, 29th St. and Ellis Ave., Chicago 60616. **Reg. deadline:** none. **Fee:** none. **Credit:** Category 1, 17-23 hours. **Contact:** William Gottschalk, MD. **Phone:** 312/942-6503.

## Cardiac Rehabilitation

### 5th Annual Cardiac Rehabilitation Symposium

**For:** MD's. Lectures/workshops, May 5-7, Milwaukee, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** \$225. **Reg. limit:** none. **Credit:** Category 1, 25 hours; AOA, 25 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Cardiology

### Clinical Mgmt. of Coronary Disease & Exercise Testing

**For:** GP's, FP's, Internists. Seminar, May 14-15, Hyatt Regency, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Dr. E., Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **Contact:** Stephen Mattingly. **Phone:** 800/525-8651 x 123.

## Family Medicine

### 34th Annual Postgraduate Seminar

**For:** FP's. Annual Meeting, May 23-27, Hyatt Regency, Chicago. **Sponsor:** Illinois Academy of Family Physicians. 1200 Harger Rd., Suite 405, Oak Brook 60521. **Fee:** Member, \$0; Non-Member, \$25. **Reg. limit:** none. **Credit:** Category 1, 12-22 hours; AAFP Prescribed, 12-22 hours. **Contact:** H. Marchmont-Robinson, MD. **Phone:** 312/325-8502.

### Nephrology

**For:** MD's. Symposium, May 27, 1:00 p.m., DuQuoin. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Medicine

## Medicine

### Nephrology-Diagnosis & Treatment of Acute & Chronic Renal Failure

**For:** MD's. Symposium, May 8, 1:00 p.m., Mt. Carmel. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Medicine

### Update in Internal Medicine, Surgery and Emergency Medicine

**For:** MD's. Lecture, May 12, Rockford. **Sponsor:** St. Anthony Hospital, 5666 E. State St., Rockford 61101. **Fee:** \$30. **Credit:** Category 1, 6 hours. **Contact:** Paul Maxwell, Jr., MD. **Phone:** 815/226-2000 x 5190.

## Medicine

### Cancer Screening & Detection

**For:** MD's. Symposium, May 19, 1:00 p.m., Marion. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Medicine

### Pancreatitis

**For:** MD's. Symposium, May 13, 1:00 p.m., Ina. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Neuroradiology

### 1982 Neuroradiology Review Course

**For:** General Radiologists, Neuroradiologists, Neurosurgeons. Course, May 1-2, Drake Oakbrook. **Sponsor:** Loyola University Medical Center, CME, 2160 S. First Ave., Maywood 60153. **Fee:** \$125; \$75, Residents. **Credit:** Category 1, 15 hours. **Contact:** Behrooz Azar-Kia, MD. **Phone:** 312/531-3928.

## Neurology

### Neurological Trauma

**For:** MD's. Lecture, May 25, 6:30 p.m., Kankakee. **Speaker:** John Mullan, MD. **Sponsor:** Riverside Medical Center, 350 N. Wall St., Kankakee 60901. **Fee:** \$3. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Lisa Mitchell. **Phone:** 815/933-1671.

## Ophthalmology

### Residents/Alumni Day

**For:** Ophthalmologists. Lectures, May 26, Chicago. **Sponsor:** Dept. of Ophthalmology, U of I, 1855 W. Taylor, Chicago 60612. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 7 hours. **Contact:** Jacob Wilensky, MD. **Phone:** 312/996-7030.

## Pathology

### Clinical Anaerobic Bacteriology

**For:** Pathologists, Technologists. Workshop, May 3-7, Chicago. **Fee:** TBA. **Reg. limit:** 48. **Credit:** Category 1, 34 hours. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison St., Chicago 60612. **Contact:** Marian Macdonald. **Phone:** 312/738-1336 x 188.

## Pathology

### Review in Clinical Chemistry

**For:** Pathologists. Workshop, May 10-14, Chicago. **Sponsor:** American Society of Clinical Pathologists, 2100 W. Harrison St., Chicago 60612. **Fee:** TBA. **Reg. limit:** 50. **Credit:** Category 1, 25 hours. **Contact:** Marion Macdonald. **Phone:** 312/738-1336 x 188.

## Surgery

### Management of Pain

**For:** MD's. Symposium, May 20, 1:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Surgery

### Burn

**For:** MD's. Symposium, May 7, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Surgery

### Symposium on Surgery

**For:** MD's. Symposium, May 7, 14, 21, 28, June 4, 11, 18, 11:00 a.m., Oak Park. **Sponsor:** Oak Park Hospital, 520 S. Maple Ave., Oak Park. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 7 hours. **Contact:** Charles Weigel, MD. **Phone:** 312/366-7870.



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# REPORT

## FOR *Illinois Physicians*

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### **BENEFIT CHANGES ANNOUNCED FOR FEDERAL EMPLOYEE PROGRAM**

The 1982 Federal Employee Program (FEP) contains a number of benefit changes and modifications which became effective on January 1. The following changes effect Blue Cross and Blue Shield of Illinois providers:

#### **BASIC SURGICAL-MEDICAL BENEFITS - GENERAL**

- **High Option**

- Payable at 100% Usual and Customary charges for:
  - Outpatient surgery
  - Accident injuries
  - X-ray, laboratory and anesthesia services relating to outpatient surgery and accidental injuries
  - Oral surgery
  - Chemotherapy
  - Suture removal
  - Treatment of burns
  - Renal dialysis
  - Electroshock therapy
- Payable at 80% Usual and Customary charges for:\*
- Inpatient surgery and anesthesia
- Obstetrical care
- Inpatient medical services including physician visits, consultations
- Medical emergency care
- Diagnostic X-ray
- Diagnostic laboratory procedures

\*The above benefits are paid at 100% of Usual and Customary charges when the 20% coinsurance reaches \$1,000 in a calendar year.

- **Low Option**

- The Low Option Indemnity Schedule has been eliminated. All services discussed under High Option are payable under Supplemental Benefits at 75% Usual and Customary charges subject to a deductible.

#### **SUPPLEMENTAL BENEFITS - GENERAL**

- **High Option**

- Payable under Supplemental Benefits at 80% Usual and Customary charges (70% U&C for mental illness) subject to a deductible of \$200 per person per calendar year for other medical care (home and office visits, drugs, ambulance, durable medical equipment). Professional services for outpatient care are available up to 50 visits per person per calendar year including visits for the treatment of mental illness. Supplemental Benefits (for other than mental illness) are paid at 100% U&C, when the Supplemental coinsurance reaches \$1,000 in a calendar year.

- **Low Option**

- Payable at 75% Usual and Customary charges subject to a deductible of \$250 per person per calendar year for other medical care, including care for mental illness described under the High Option Plan.



Professional services for outpatient care are available for up to 25 visits per person per calendar year including visits for treatment of mental illness.

**INHOSPITAL CARE (INCLUDING TREATMENT  
OF  
MENTAL ILLNESS)**

- **High Option**
  - Unlimited days (limited to 60 days for the treatment of mental illness) per calendar year.
- **Low Option**
  - 180 days (limited to 30 days for the treatment of mental illness) per calendar year.

**ABORTIONS**

- Under High and Low Option, benefits are no longer provided for abortions under this plan except when the life of the mother would be endangered if the fetus were carried to term.

**ALCOHOL REHABILITATION**

- The alcoholism treatment benefit has been eliminated under both High and Low Option.

**CONCURRENT PHYSICIAN’S CARE**

- Under both High and Low Option, Basic Surgical-Medical Benefits for concurrent care during admissions covered by Basic Benefits are provided for one physician per day other than the attending physician for a condition not related to the primary diagnosis or because of the medical complexity of the patient’s condition. Benefits for concurrent care are modified to include only one physician per day in addition to the attending physician. Supplemental Benefits are available for additional concurrent care visits required because of the medical complexity of the patient’s condition when the days of care are covered by either Basic or Supplemental Benefits. No benefits are available for concurrent care for mental illness beyond the 60 day High Option and 30 day Low Option limits.

**ASSISTANCE AT SURGERY**

- Under High and Low Option, benefits for physician assistance at surgery are provided when required due to the complexity of the surgical procedure. Providers are no longer required to certify that hospital staff personnel were unavailable.

**DENTAL BENEFITS**

- Basic dental benefits under *High Option* are provided for oral examinations, dental X-rays, prophylaxis, and fluoride treatments only. The fee schedule allowances for these services have been increased by 20%.

**BASIC CHILDREN’S BENEFIT**

- Dental and vision care for dependent children through age 12 are covered as a special children’s benefit (not subject to the deductible *under Low Option* for up to \$200 per family per calendar year).

Note: The Identification Number for each Federal Employee begins with the letter “R” followed by eight numerals, for example, R12345678. In addition to the Identification Number, the Blue Cross and Blue Shield Card carries an Enrollment Code, for example FEP101, FEP102, etc. Please include both the Identification Number and the Enrollment Code when submitting claims for Federal Employees.

Please make a note of the following telephone number changes . . . . Bill Livingston, 938-7885 and Customer Service, 938-7500.

# Medicaid-Medicare-Champus Report

## MEDICAID

Recent reports from physicians to ISMS have focused on the prolonged delay in the Medicaid payment cycle. Since MMIS implementation, participating physicians have experienced delays in the payment cycle for pre-MMIS "clean" claims — those claims not requiring hand-pricing or additional information from the provider. Also, MMIS claims submitted to the Illinois Department of Public Aid after October, 1981, have added to the backlog and substantially increased the processing time of pre-MMIS claims. Some physicians have received little or no reimbursement on pre-MMIS claims as a result of MMIS implementation.

ISMS has responded to the numerous problems associated with the approximately \$92 million IDPA payment backlog by conducting aggressive negotiation sessions with IDPA Director Jeffrey Miller, and Medical Assistance Program Director Betsy Skloot. The ISMS Executive Committee and the ISMS Committee on Third Party Payment Processes met with these officials in an attempt to constructively resolve these and other IDPA payment problems. To decrease the Department's payment cycles for both pre-MMIS (DPA 132) claims and MMIS (DPA 2360) claims, IDPA administrators have committed to ISMS that the following actions will be undertaken beginning January, 1982.

- IDPA claims processing will work overtime to decrease the Department's claims-on-hand at peak processing periods (e.g., beginning of each month.)
- Additional personnel will be added and existing staff will be reassigned to process pre-MMIS and MMIS claims.
- The Department will seek to correct the claim processing operating procedures by analyzing and revising system edit requirements to reduce errors that result in claim rejections.
- IDPA will also expand quality control procedures to detect in-house processing problems and take remedial action.

IDPA indicates that these steps will reduce the pre-MMIS claims processing cycle significantly. IDPA Director Miller has assured the ISMS Executive Committee that the Department should return to a normal physician payment schedule by February, 1982. ISMS will closely monitor the Department's implementation of these operations and will meet regularly with IDPA until the problems are resolved.

## CHAMPUS

A new policy has been promulgated by the Wisconsin Physicians Service, the CHAMPUS fiscal intermediary in Illinois, to accommodate the processing of CHAMPUS/CHAMPVA claims on the Universal Health Insurance Claim Form (HCFA 1500). Currently, physicians providing services to CHAMPUS/CHAMPVA beneficiaries submit their billings on the CHAMPUS 500 claim form.

Wisconsin Physicians Service (WPS) will now accept *both* the CHAMPUS 500 and the HCFA 1500 claim forms. Instructions for proper completion of



the HCFA 1500 for CHAMPUS claims will be forthcoming from WPS. Physicians should refrain from utilizing the HCFA 1500 claim form until this information has been received. ISMS will continue to monitor this change in WPS policy and will advise you on developments as they become available. Physicians or their office staff having problems with CHAMPUS reimbursement policies may contact Wisconsin Physicians Service at their toll-free number, 800-356-7240. Routine inquiries from members of ISMS District Three may also be addressed to Christine Szuflita, Chicago Medical Society. Similarly, members from the balance of the state may address CHAMPUS inquiries to the ISMS Division of Professional Relations.

## MEDICARE

### Revised Medicare Procedure Code Books

EDS-Federal expects to begin distribution of its revised Medicare Part B Procedure Code Book during February 1982. **THIS BOOK IS BEING SENT BY WRITTEN REQUEST ONLY.** Physicians or office staff desiring a revised procedure code manual should send their request to: EDS-Federal Corporation, Professional Relations Dept., 999 E. Touhy, #500 - DesPlaines, Illinois 60018 - Attn: "Procedure Code Book Request." The physician's name, address, telephone number and specialty should be included on all requests for a free code book. Physicians with questions pertaining to Medicare claims may contact EDS-Federal for assistance at their toll-free number in Chicago, 800-942-5261. Additional assistance with Medicare claims may be obtained by contacting your ISMS Field Representative.

On a related front, EDS-Federal has changed specific laboratory codes for Medicare Part B billings. Procedure Code #8179 - "Electrolytes, Blood" has been removed from the Medicare procedure code file. The EDS-Federal code for blood electrolyte tests has been changed to Procedure Code #8004. The procedure code for "complete blood count (CBC), not automated" - #8462 has also been deleted from the procedure code file by EDS. The new EDS code is Procedure Code #8460 - "Complete blood count (CBC), automated and not automated."

### Medicare Brochure Available

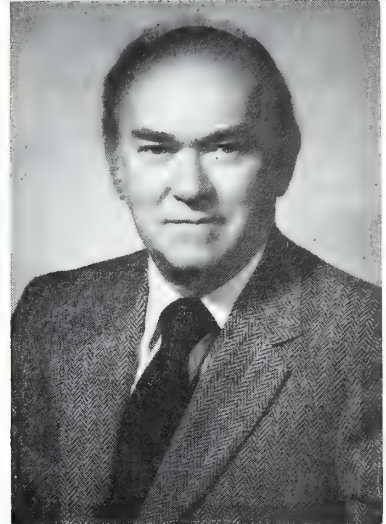
The AMA's Council on Medical Services has updated its informative brochure, *Physicians Fees Under Medicare*. This publication, revised to reflect the 1981 changes in the Medicare law, illustrates how Medicare fee profiles and levels of reimbursement are established. Physicians desiring a copy may call the American Medical Association's Department of Health Care Financing and Organization in Chicago at 312-751-5974.

## ERRATA

We would like to clarify a statement in the December, 1981, "Medicaid-Medicare CHAMPUS Report," (Volume 160, No. 6, December, 1981). The sentence: "ISMS strongly suggests that physicians consult this updated edition [of the Medicare Procedure Code Book] and update their Medicare claims with the new procedure codes," failed to mention ISMS House of Delegates policy on CPT-IV. The adoption of CPT-IV by third party payors is a goal actively pursued by ISMS, and CPT-IV remains the only ISMS-endorsed coding system. EDS-Federal has sought permission to use CPT-IV and has been turned down by HCFA.

# President's Page

## The Competitive Alternative



Little has been heard in recent years about national health insurance or a national health service. When these issues were *again* put to rest several years ago, a comment frequently heard was that NHI or NHS was not likely to occur during times of affluence. Since today's multiple budget crunches hardly characterize the present as a time of affluence, it may be useful to assess the present societal and governmental dynamics and to project our options and potential future.

There can be no doubt that health care costs are increasing. We can rationally explain these escalations, but the fact remains that costs are increasing more rapidly than the rates of inflation and other national expenditures.

Although the national mood is toward deregulation, the health care cost trend has not gone unnoticed by the nation's Congress. For the moment, however, further regulation probably will yield to the competitive approach.

State and federal funds are becoming more limited, so competition among various groups and individuals for available funds will become more vigorous. Some of these competitors can offer government a product for investment or a growth projection for the Gross National Product. Others have a constituency that is strong and vocal and is in favor of recreation, conservation, defense, social programs, food stamps, etc.

Pragmatically, we must realize that health care does not offer a product or increase the GNP and is seldom an enjoyable experience. As a result, health care—as a prospective competitor—may not be as strong as the other constituencies.

Meanwhile, cost shifting is increasing in magnitude as the federal and state cuts in Medicare/Medicaid move costs to the private sector. In more subtle ways, shifting occurs in the form of a deductible or co-payment which shifts costs directly to the individual patient. Both of these mechanisms ultimately result in additional demands on Congress to reduce these individual costs.

If pressure upon Congress increases from groups interested in their particular issues and from patients paying higher out-of-pocket costs, Congress may be forced to respond. Experience tells us that the usual Congressional response is further regulation. But Congress is well aware that regulation in other areas has not reduced costs.

The only cost containment option left then may be to nationalize the health insurance industry and to control the providers—the physicians—via a national health service mechanism. The fastest route to that undesirable endpoint could be to support the status quo, and to ignore the competitive alternative now before us.

A handwritten signature in dark ink, reading "Fred Z. White".

Fred Z. White, M.D., President



One of nature's  
most predictable modalities...



*Lepus lagopus*

# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a fifty-six year old man who was in good health until he sustained a myocardial infarction. His only coronary risk factor was heavy cigarette smoking. His course in the hospital after the myocardial infarction was uncomplicated. One month later he developed crushing substernal chest pain related to activity. These were promptly relieved by nitroglycerin. The pains gradually became associated with lesser and lesser levels of exertion. Finally, the pains came at rest. Nitroglycerin was always effective in relieving the pains but, as the pain frequency increased, more nitroglycerin tablets were required for relief. Propranolol at a dose of 160mg. per day and isosorbide dinitrate 20mg. per day in divided doses failed to reverse the accelerated pattern of the angina. The patient was hospitalized and a coronary angiogram was performed. The left ventricular end diastolic pressure was slightly elevated to 16mmHg. The left ventricular angiogram was normal in size with an inferobasal area of akinesis and inferoapical area of hypokinesis. The right coronary artery was a large dominant vessel with a 70% obstruction proximally and a 90% obstruction at the takeoff of the posterior descending artery. The left anterior descending artery had a 70% proximal obstruction and the left circumflex artery a 50% proximal obstruction. The twelve lead ECG was obtained prior to the cardiac catheterization.*



## Questions

### 1. The ECG shows:

- A. Left ventricular hypertrophy.
- B. Inferior wall (diaphragmatic) myocardial infarction.
- C. Wolff-Parkinson-White syndrome.
- D. Posterior wall (dorsal wall) myocardial infarction.
- E. Lateral wall myocardial infarction.

### 2. The following statement(s) is/are true:

- A. This patient has triple vessel coronary artery disease.


- B. The prognosis for this patient is related to the extent of myocardial damage or left ventricular dysfunction.
- C. A history of old myocardial infarction, congestive heart failure, the development of bundle branch block, and complex ventricular arrhythmias in the presence of acute myocardial infarction also worsen the prognosis.
- D. Angina pectoris following a myocardial infarction has a bad prognosis.
- E. All of the above.

(Continued on page 214)



**METHYLDOPA?**  
**RESERPINE?**  
**OR**  
**INDERAL<sup>®</sup>**  
(PROPRANOLOL HCl)





# THE CHOICE IS CLEAR

There was a time when you had little choice between such troublesome reserpine side effects as nasal stuffiness or depression, and the postural hypotension, sexual dysfunction, or development of tolerance to methyldopa. Today, it's a different story.

With INDERAL you have a logical choice. Patients rarely feel worse while they're getting better. And as far as tolerance is concerned — none has been reported with INDERAL. Its effectiveness is sustained, even in long-term therapy.

Proper patient selection is always important. INDERAL should be used only in the absence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.\*

INDERAL permits you to achieve smooth, effective control of blood pressure with few troublesome side effects.\* Moreover, because side effects are usually not dose-related, higher doses can be prescribed with confidence.

INDERAL. The choice is clear when it comes to well-tolerated and effective control of hypertension.

**INDERAL<sup>®</sup>**  
(PROPRANOLOL HCl)

**B.I.D. FOR  
HYPERTENSION**

**40 MG AND 80 MG TABLETS**

\*Please see following page  
for Brief Summary of  
Prescribing Information.



# THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD

## INDERAL® (PROPRANOLOL HCl) B.I.D. FOR HYPERTENSION

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

**Inderal® BRAND OF propranolol hydrochloride A beta-adrenergic blocking agent**

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG.

### CONTRAINDICATIONS

INDERAL is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

### WARNINGS

**CARDIAC FAILURE:** Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

**IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE,** continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

**IN PATIENTS WITH ANGINA PECTORIS,** there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

**IN PATIENTS WITH THYROTOXICOSIS,** possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

**IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME,** several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

**IN PATIENTS DURING ANESTHESIA** with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

**IN PATIENTS UNDERGOING MAJOR SURGERY,** beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

**IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM** (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA:** Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**USE IN PREGNANCY:** The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

### PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

### ADVERSE REACTIONS

**Cardiovascular:** bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura

**Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics

**Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis

**Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

**Respiratory:** bronchospasm

**Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

**Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

### ORAL

#### DOSAGE AND ADMINISTRATION

**HYPERTENSION—Dosage must be individualized.** The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

#### PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

#### INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

#### OVERDOSAGE OR EXAGGERATED RESPONSE

**IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:**

**BRADYCARDIA—ADMINISTER ATROPINE** (0.25 to 1.0 mg): IF THERE IS NO RESPONSE TO VAGAL BLOCKADE, ADMINISTER ISOPROTERENOL CAUTIOUSLY.

**CARDIAC FAILURE—DIGITALIZATION AND DIURETICS.**

**HYPOTENSION—VASOPRESSORS, e.g., LEVATERENOL OR EPINEPHRINE** (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

**BRONCHOSPASM—ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.**

#### HOW SUPPLIED

INDERAL (propranolol hydrochloride)

**TABLETS**  
No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

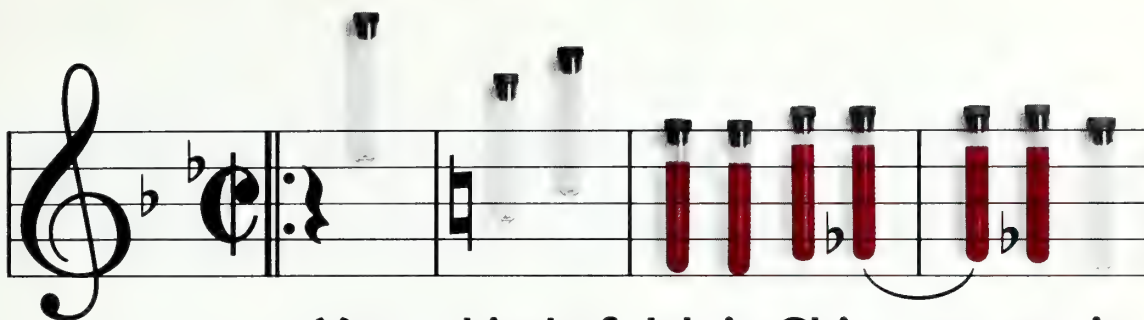
#### INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as: 1 ml ampuls in boxes of 10.

7526/581

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AYERST LABORATORIES  
New York, N.Y. 10017



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## SmithKline Clinical Laboratories, Inc.

Since 1978, Chicago area hospitals have relied on SmithKline Clinical Laboratories Inc. for reference testing and for expert support in one of the most challenging areas of laboratory medicine—STAT toxicology testing. Now we've expanded our services so that physician practices can also benefit from our quality routine, reference and STAT testing 24 hours a day, every day.

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Why is SKCL your kind of lab? Because we can offer your practice quality testing, reliable services, competitive prices—plus the convenience and speed of having your test needs fulfilled by a local laboratory. We make sure your samples get to our laboratory faster... so that results get back to your office sooner.

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We go out of our way to provide the following services: Daily specimen pickups, 24-hour results on most tests, four-hour STAT

testing available on a 24-hour basis, telephone reporting of grossly abnormal and STAT results, free specimen collection materials and the option of direct-to-you or patient billing.

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You can rely on SKCL for quality: all testing is performed by our highly trained technical staff and quality control procedures meet or exceed the standards of CAP, CDC and NCCLS.

### Your kind of prices

SKCL prices are very competitive (\$8.75 for a 26-chemistry panel for example, or \$3.00 for a total hematology panel including platelets) on a full range of tests.

### See for yourself

Why not see if SKCL is your kind of lab? We'll provide all the materials you'll need for a personal evaluation of our services and quality. Just call SKCL at **(312) 595-1060**.

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a SmithKline service



# Abstracts of Action

January 23, 1982

Palmer House  
Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

## BOARD OF TRUSTEES TO SEEK DUES INCREASE

The Board of Trustees approved a 1982 ISMS budget reflecting a \$45,250 surplus, with an anticipated income of \$3,679,462 and expenditures of \$3,634,212. However, for 1983, a deficit would be anticipated.

Because of the impact of high inflation rates on program costs, 1983 expenses are expected to be substantially more than 1982. As a result, the Board will recommend a \$50 dues increase at the Society's annual meeting in April. If approved, the increase will take effect Jan. 1, 1983.

The recommendation will be made with the understanding that the dues amount will be evaluated at least annually . . . and may require an additional future increase pending information on ISMS headquarters occupancy costs, computer facility costs, and shared service reimbursement from the Illinois State Medical Insurance Services.

The Board's action is based on an evaluation of the Society's current financial situation by Ernst & Whinney, certified public accountants, which estimated that the ISMS Operating Fund—including funds appropriated for contingency—will have accumulated a significant deficit by the end of 1983.

ISMS' current dues are \$203. AMA data shows that:

- The median dues for state medical societies in 1981 was \$220; and
- 30 state medical societies had higher dues than ISMS last year, with Washington, D.C. (\$495), Wisconsin (\$380), and Alabama (\$350) being the highest.

## SEEK TO RESOLVE MEDICAID PAYMENT BACKLOG

The Executive Committee and Third Party Payment Processes Committee will meet with IDPA Director Jeffrey Miller Feb. 17 to discuss the Department's attempts to "clean-up" its payment backlog.

Prior to the meeting, ISMS will press the Department to either eliminate or modify substantially the edits in the system which are causing bills to suspend or reject. The Society also will conduct spot checks of Illinois physicians to determine the current status of payment. If results of the Feb. 17th meeting are unsatisfactory, the Society will seek a meeting with the Governor.

## OPPOSE IDPA's LABORATORY VOLUME PURCHASE PLAN

The Board will oppose the Illinois Department of Public Aid's proposed Laboratory Volume Purchase Plan because "it is not in the best interest of patients." The Plan proposes that one central laboratory be designated to conduct all out-patient laboratory services for public aid recipients. The use of any other laboratory would be prohibited under the plan.

*(Continued on page 207)*

# Your Angina patients could fly coast to coast on the long-acting effects of one tablet.

Bioavailability findings\* of Oral, Sublingual and Chewable Cardilate® dosage forms in volunteers demonstrated that the Oral (swallowed) 10mg Tablet provided a 6-hour duration of pharmacologic effect; more than 3 times longer than when given sublingually, or as the chewable Tablet. Cardilate Oral Tablets are recommended for the prophylaxis and long-term treatment of patients with frequent or

recurrent anginal pain and reduced exercise tolerance associated with angina pectoris.

\*Hannemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. C., Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. R.: Digital Plethysmography For Assessing Erythrityl Tetranitrate Bioavailability. Clin Pharmacol and Ther 29:35-39, 1981.

**Cardilate®**  
(erythrityl tetranitrate)  
Oral Tablets

#### **CARDILATE® (ERYTHRITYL TETRANITRATE)**

**INDICATIONS:** Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris rather than for the treatment of the acute attack of angina pectoris since its onset is somewhat slower than that of nitroglycerin.

**CONTRAINDICATIONS:** Idiosyncrasy to this drug.

**WARNING:** Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

**PRECAUTIONS:** Intraocular pressure is increased therefore caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.

**ADVERSE REACTIONS:** Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine and many other agents. An occasional individ-

ual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur.

#### **DOSAGE AND ADMINISTRATION**

Oral / Sublingual Tablets: Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg. prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

#### **HOW SUPPLIED:**

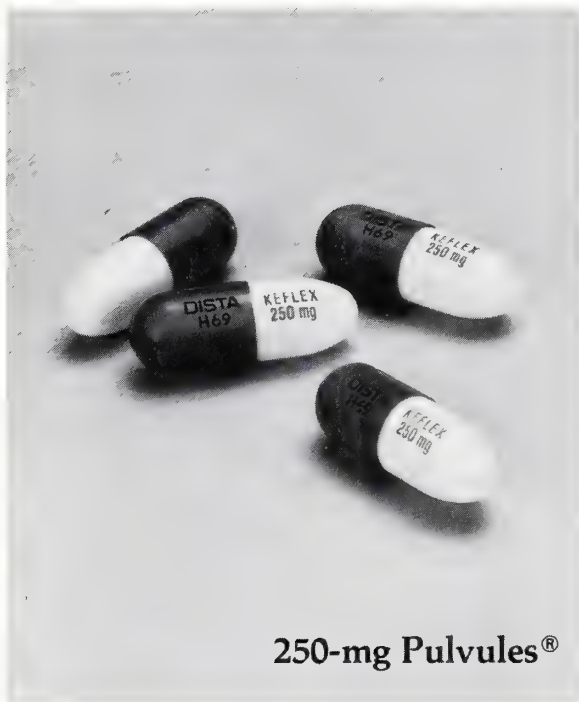
**CARDILATE** (Erythrityl Tetranitrate) TABLETS (Scored)  
for ORAL or SUBLINGUAL USE 5 mg: Bottle of 100;  
10 mg: Bottles of 100 and 1000; 15 mg: Bottle of 100

**Burroughs Wellcome Co.,**  
Research Triangle Park, North Carolina 27709

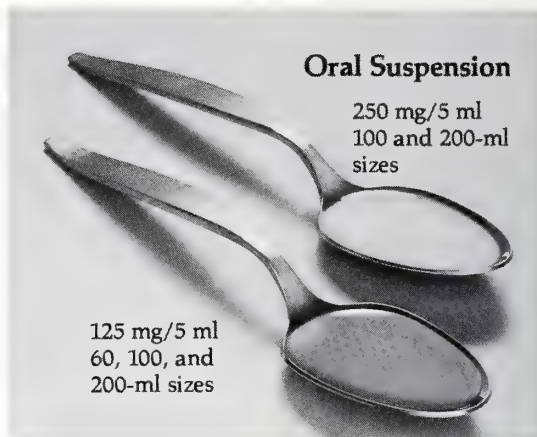




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## Oral Suspension

250 mg/5 ml  
100 and 200-ml  
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125 mg/5 ml  
60, 100, and  
200-ml sizes



## Pediatric Drops

100 mg/ml  
10-ml size

# Keflex®

cephalexin

Additional information available  
to the profession on request.



000823

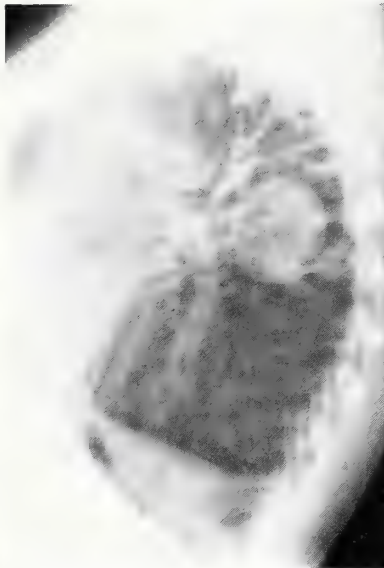
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Division of Eli Lilly and Company  
Indianapolis, Indiana 46285  
Mfd. by Eli Lilly Industries, Inc.  
Carolina, Puerto Rico 00630

# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This month's viewbox was prepared by John McCaffrey, M.D. and Terrence C. Demos, M.D.*

*All these patients have the same disease causing these radiographic patterns.*



**Figures 1 & 2**

**Patient I:** PA and lateral chest in a patient with a past history of cavitary tuberculosis who now has hemoptysis.



**Figure 5**

**Patient III:** PA chest in a patient with known lymphoma who has a cavitary right upper lobe lesion.



**Figures 3 & 4**

**Patient II:** PA chest and lateral tomogram of branching right lower lobe lesion in an asthmatic.

## Your diagnosis?

- (a) Bronchiolar carcinoma
- (b) Tuberculosis
- (c) Pulmonary aspergillosis
- (d) Pneumonia "pseudotumor"
- (e) Pulmonary hamartoma

*(Continued on page 203)*



**BECAUSE  
A THIAZIDE ALONE  
CAN ONLY DO  
SO MUCH...**

**AND YET  
CAN DO  
TOO MUCH.**



# INCREASE CONTROL WITHOUT INCREASING POTASSIUM PROBLEMS.

## **A dependable means to long-term blood pressure control.**

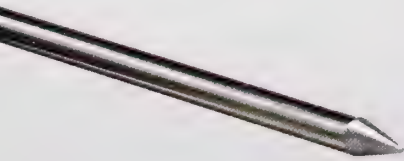
Many times, a diuretic alone can't keep hypertension in check. *INDERIDE*, however, can pick up where thiazide therapy leaves off.

The combination of propranolol HCl, the world's most trusted beta blocker, and hydrochlorothiazide, the standard among diuretics, enables *INDERIDE* to exert an additive antihypertensive effect.<sup>1,2</sup> In fact, a propranolol/hydrochlorothiazide regimen maintained blood pressure below 90 mm Hg in 81.8% to 86.4% of patients followed for 6 to 18 months of therapy.<sup>1</sup>

## **Low thiazide dosage means reduced risk of hypokalemia.**

When thiazides are prescribed in doses greater than 50 mg/day, the potential for hypokalemia increases substantially. What's more, the greater the fall in serum K<sup>+</sup>, the greater the risk of hypokalemia-induced PVCs.<sup>3,4</sup>

With *INDERIDE*, the additive hypotensive effect of propranolol HCl allows the effective dose of hydrochlorothiazide to be kept low (25 mg b.i.d.). And by lowering the daily dose of diuretic, *INDERIDE* also lowers the potential for diuretic-induced side effects. Potassium problems are less likely to occur—yet blood pressure can be controlled consistently.



# **INDERIDE<sup>®</sup>**

Each tablet contains *INDERAL<sup>®</sup>* (propranolol HCl) 40 mg or 80 mg, and hydrochlorothiazide 25 mg | **B.I.D. 40/25  
80/25**

## **When you know you need more than a thiazide.**

Please see Brief Summary of Prescribing Information on following page.



BRIEF SUMMARY  
(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

## INDERIDE®

BRAND OF  
propranolol hydrochloride  
(INDERAL®)  
and hydrochlorothiazide

No. 474—Each IINDERIDE®-40/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	40 mg
Hydrochlorothiazide	25 mg
No. 476—Each IINDERIDE®-80/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	80 mg
Hydrochlorothiazide	25 mg

**WARNING:** This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

**DESCRIPTION:** IINDERIDE combines two antihypertensive agents: IINDERAL (propranolol hydrochloride), a beta-adrenergic blocking agent, and hydrochlorothiazide, a thiazide diuretic-antihypertensive.

**INDICATION:** IINDERIDE is indicated in the management of hypertension. (See boxed warning.)

**CONTRAINDICATIONS:** Propranolol hydrochloride (INDERAL®): Propranolol hydrochloride is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

**Hydrochlorothiazide:** Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

**WARNINGS:** Propranolol hydrochloride (INDERAL®): CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

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IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in re-starting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA** Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

**USE IN PREGNANCY:** Propranolol hydrochloride (INDERAL®): The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

**Hydrochlorothiazide:** Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**Nursing Mothers:** Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

**PRECAUTIONS:** Propranolol hydrochloride (INDERAL®): Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

**Hydrochlorothiazide:** Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

**ADVERSE REACTIONS:** Propranolol hydrochloride (INDERAL®): Cardiovascular:

bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

**Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

**Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

**Respiratory:** bronchospasm

**Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Miscellaneous:** reversible alopecia. Oculocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**Hydrochlorothiazide:** **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

**Central Nervous System:** dizziness, vertigo, paresthesias, headache, xanthopsia.

**Hematologic:** leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

**Cardiovascular:** orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

**Hypersensitivity:** purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

**Other:** hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

**DOSEAGE AND ADMINISTRATION:** The dosage must be determined by individual titration (see boxed warning).

Hydrochlorothiazide is usually given at a dose of 50 to 100 mg per day. The initial dose of propranolol is 40 mg twice daily and it may be increased gradually until optimal blood pressure control is achieved. The usual effective dose is 160 to 480 mg per day.

One to two IINDERIDE tablets twice daily can be used to administer up to 320 mg of propranolol and 100 mg of hydrochlorothiazide. For doses of propranolol greater than 320 mg, the combination products are not appropriate because their use would lead to an excessive dose of the thiazide component.

When necessary, another antihypertensive agent may be added gradually beginning with 50 percent of the usual recommended starting dose to avoid an excessive fall in blood pressure.

**OVERDOSAGE OR EXAGGERATED RESPONSE:** The propranolol hydrochloride (INDERAL®) component may cause bradycardia, cardiac failure, hypotension, or bronchospasm.

The hydrochlorothiazide component can be expected to cause diuresis. Lethargy of varying degree may appear and may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function, and in the absence of significant serum electrolyte changes or dehydration. The mechanism of central nervous system depression with thiazide overdosage is unknown. Gastrointestinal irritation and hypermotility can occur; temporary elevation of BUN has been reported, and serum electrolyte changes could occur, especially in patients with impairment of renal function.

**TREATMENT:** The following measures should be employed: GENERAL—If ingestion is, or may have been, recent, evacuate gastric contents taking care to prevent pulmonary aspiration. BRADYCARDIA—Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. CARDIAC FAILURE—Digitalization and diuretics. HYPOTENSION—Vasopressors, e.g., levaterenol or epinephrine. BRONCHOSPASM—Administer isoproterenol and aminophylline. STUPOR OR COMA—Administer supportive therapy as clinically warranted. **GASTROINTESTINAL EFFECTS:** Though usually of short duration, these may require symptomatic treatment. **ABNORMALITIES IN BUN AND/OR SERUM ELECTROLYTES—**Monitor serum electrolyte levels and renal function; institute supportive measures as required individually to maintain hydration, electrolyte balance, respiration, and cardiovascular-renal function.

**HOW SUPPLIED:** No. 474—Each IINDERIDE®-40/25 tablet contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 476—Each IINDERIDE®-80/25 tablet contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

**References:** 1. Veterans Administration Cooperative Study Group on Antihypertensive Agents: J.A.M.A. 237:2303 (May 23) 1977. 2. Bravo, E.L., Tarazi, R.C., and Dustan, H.P.: N. Engl. J. Med. 292:66 (Jan. 9) 1975. 3. Hollifield, J.W., and Slaton, P.E.: Acta Med. Scand. [Suppl.] 647:67, 1981. 4. Holland, O.B., Nixon, J.V., and Kuhnert, L.: Am. J. Med. 70:762 (Apr.) 1981.

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# Guest Editorial

## *Reflections on Positions and Goals*

BY FRED Z. WHITE, M.D., M.A. (ED.)/CHILLICOTHE  
ISMS PRESIDENT

In this changing society in which we find ourselves, the only constancy is inconsistency. Changes and movement continue and often, adrift on this societal sea, I find it difficult to know where I am or where I'm going. This is particularly true with the number of changes—new ideas—suggestions—methodologies—before us now.

Valuable perspective might be derived from a cursory review of the August *IMJ* table of contents. Articles included the following titles:

- Food, Clothing, Plumbing Should Be Free To The Public As Well As Medicine
- Dance Marathons
- The Family Doctor
- Life and Problems Under A Medical Utopia
- The Feminine Barrage Against Medical Men
- Mass Of New Laws Proves Tendency Toward Too Much Government

A quotation from the last article cited above is further enlightening:

"When John Citizen, U.S.A., lifts his tax-harrassed brow, blinks, clears his throat and blandly remarks: 'So?' it is indicative that he has heard of new triple-compound fractures of law-making records.

"While John is a patient, good-natured fellow, ever mindful of the rights, well-being and happiness of his fellow men, he has become somewhat skeptical about the trend in government. This era of superlegislation, bureaucratic supercontrol and super-tax bills has just about reached the intolerant stage for John.

"... If it were possible for John to read one new law each minute—for instance one like the federal income tax law—and he spent eight hours each day at his task, Sundays and holidays included, the end of the year would find John with some 25,000 unread laws."

(*IMJ*, 44: 2, August 1923, pages 85-87)

The notion of society as an ocean may be a useful analogy. Some of the motion that occurs in that sea is simply Brownian, some of it is an up and down swell that adds to one's vertigo, but doesn't really move anywhere but under, and through it all there is a rather constant drift. There are currents and there are cross-currents. The most significant change in current and force is the increased pressure from society and government. While on this allegorical ocean, our major concern is the integrity of our craft, keeping afloat and bailing if necessary. While not denigrating that necessity, it is also imperative to understand the many motions that are occurring and the reason and direction of their currents.

It is important to have a perspective and to take one's bearings. It is important to know which ocean, in the broadest sense, one floats upon. It is also important to recognize the currents and their effect and to gain a sense of where we are in relation to where we have been and where we intend to go, in order to navigate with any degree of success.

Having recently gone through this exercise of locating myself and developing future goals, like anyone who fancies himself to be an educator and who has just gained a new insight, and presented with the further temptation of a captive audience, I hasten to share my experience with you.

Where do I see us going? It is important, in my view, to have principles firmly in mind when we try to negotiate future goals. I am sure that negotiations will be the manner in which these goals are reached. To that concern, if we become fixed on specifics, we are likely to lose direction and may lose the purposes for which we strive. There-



fore, I have tried to keep in mind the principles that are important and non-negotiable but maintain a willingness to work with specifics that are more negotiable. Among those which I believe we in medicine must maintain are the following:

1. Patient freedom to choose his physician and the system to which that physician ascribes. Equally, physician freedom to select patients by whatever means he chooses. Without that freedom of choice, quality medicine cannot occur.
2. Responsibility and authority must co-exist in order to have accountability. To have the responsibility for health care without the authority to deliver it leads to lack of accountability. We must be accountable to our peers and to our patients. I am convinced that we are responsible individuals and are willing to be held accountable as long as we have the authority to do so. Regulation will not allow this, inasmuch as that authority will then belong to the regulators and that would be the antithesis of quality and freedom.
3. Local decision making—To me this should be at the most basic level practical. It is my conviction, and perhaps my paranoia, that the centralists or federalists would prefer to have planning criteria, and authority at the central or federal level. The increasing loads and re-

sponsibilities coupled with decreasing funding for PSROs and HSAs may be the way in which they are programmed by the federal government to fail as local planning and monitoring agencies. Once they fail, central authority and regulation will be the logical and reasonable alternative. Again, this is an alternative that is unacceptable by the principles that I have outlined.

4. A pluralistic system—I am certain that many systems allowing both physicians and patients a choice—when they have the freedom to make that choice—will be to everyone's advantage.

As long as the principles of a pluralistic system: freedom of choice, local decision making and accountability, are preserved, then regulation and other mechanisms oppressive to us and to the quality of medicine we practice cannot occur.

#### *Mechanisms and Methodologies*

Specifics in plans and planning can be explored and tried without any professional loss. The very effort and the process, showing our willingness to look, listen, and try, becomes more important than any attempt to stonewall. Resistance can only be perceived as self-protecting and self-serving. ◀

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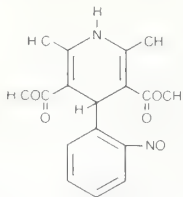
**THE FIRST ORAL  
CALCIUM CHANNEL  
BLOCKER  
FOR THE  
MANAGEMENT OF  
ANGINA PECTORIS**

**NEW**  
**PROCARDIA<sup>®</sup>**  
**(NIFEDIPINE)** Capsules 10 mg

*Please see PROCARDIA<sup>®</sup> prescribing information on next page.*



**DESCRIPTION:** PROCARDIA (nifedipine) is an antihypertensive drug belonging to a new class of pharmacological agents, the calcium channel blockers. Nifedipine is 3,5-pyridinedicarboxylic acid, 1,4-dihydro-2,6-dimethyl-4-(2-nitrophenyl)-, dimethyl ester, C<sub>17</sub>H<sub>18</sub>N<sub>2</sub>O<sub>6</sub>, and has the structural formula:



Nifedipine is a yellow crystalline substance, practically insoluble in water but soluble in ethanol. It has a molecular weight of 346.3. PROCARDIA CAPSULES are formulated as soft gelatin capsules for oral administration each containing 10 mg nifedipine.

**CLINICAL PHARMACOLOGY:** PROCARDIA (nifedipine) is a calcium ion influx inhibitor (slow channel blocker or calcium ion antagonist) and inhibits the transmembrane influx of calcium ions into cardiac muscle and smooth muscle. The contractile processes of cardiac muscle and vascular smooth muscle are dependent upon the movement of extracellular calcium ions into these cells through specific ion channels. PROCARDIA selectively inhibits calcium ion influx across the cell membrane of cardiac muscle and vascular smooth muscle without changing serum calcium concentrations.

**Mechanism of Action:** The precise means by which this inhibition relieves angina has not been fully determined, but includes at least the following two mechanisms:

1) **Relaxation and prevention of coronary artery spasm:** PROCARDIA dilates the main coronary arteries and coronary arterioles, both in normal and ischemic regions, and is a potent inhibitor of coronary artery spasm, whether spontaneous or ergonovine-induced. This property increases myocardial oxygen delivery in patients with coronary artery spasm, and is responsible for the effectiveness of PROCARDIA in vasospastic (Prinzmetal's or variant) angina. Whether this effect plays any role in classical angina is not clear, but studies of exercise tolerance have not shown an increase in the maximum exercise rate-pressure product, a widely accepted measure of oxygen utilization. This suggests that, in general, relief of spasm or dilation of coronary arteries is not an important factor in classical angina.

2) **Reduction of oxygen utilization:** PROCARDIA regularly reduces arterial pressure at rest and at a given level of exercise by dilating peripheral arterioles and reducing the total peripheral resistance (afterload) against which the heart works. This unloading of the heart reduces myocardial energy consumption and oxygen requirements and probably accounts for the effectiveness of PROCARDIA in chronic stable angina.

**Pharmacokinetics and Metabolism:** PROCARDIA is rapidly and fully absorbed after oral administration. The drug is detectable in serum 10 minutes after oral administration, and peak blood levels occur in approximately 30 minutes. It is highly bound by serum proteins. PROCARDIA is extensively converted to inactive metabolites and approximately 80% of PROCARDIA and metabolites are eliminated via the kidneys. The half-life of nifedipine in plasma is approximately two hours. There is no information on the effects of renal or hepatic impairment on excretion or metabolism of PROCARDIA.

**Hemodynamics:** Like other slow channel blockers, PROCARDIA exerts a negative inotropic effect on isolated myocardial tissue. This is rarely, if ever, seen in intact animals or man, probably because of reflex responses to its vasodilating effects. In man, PROCARDIA causes decreased peripheral vascular resistance and a fall in systolic and diastolic pressure, usually modest (5–10 mm Hg systolic), but sometimes larger. There is usually a small increase in heart rate, a reflex response to vasodilation. Measurements of cardiac function in patients with normal ventricular function have generally found a small increase in cardiac index without major effects on ejection fraction, left ventricular end diastolic pressure (LVEDP) or volume (LVEDV). In patients with impaired ventricular function, most acute studies have shown some increase in ejection fraction and reduction in left ventricular filling pressure.

**Electrophysiologic Effects:** Although, like other members of its class, PROCARDIA decreases sinoatrial node function and atrioventricular conduction in isolated myocardial preparations, such effects have not been seen in studies in intact animals or in man. In formal electrophysiologic studies, predominantly in patients with normal conduction systems, PROCARDIA has had no tendency to prolong atrioventricular conduction, prolong sinus node recovery time, or slow sinus rate.

**INDICATIONS AND USAGE: I. Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

**II. Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta-blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

**CONTRAINDICATIONS:** Known hypersensitivity reaction to PROCARDIA.

**WARNINGS: Excessive Hypotension:** Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

**Increased Angina/Beta Blocker Withdrawal:** Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

**Congestive Heart Failure:** Rarely, patients usually receiving a beta blocker have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event, as the unloading effect of PROCARDIA would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the aortic valve.

**PRECAUTIONS: General:** Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. See Warnings.

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to

Diagnosis: Information: Beta-adrenergic blocking agents: See Indications and Warnings. Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Carcinogenesis, mutagenesis, impairment of fertility: Nifedipine was administered orally to rats for two years and was not shown to be carcinogenic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. *In vivo* mutagenicity studies were negative.

Pregnancy: Pregnancy category C. Nifedipine has been shown to be teratogenic in rats when given in doses 30 times the maximum recommended human dose. Nifedipine was embryotoxic (increased fetal resorptions, decreased fetal weight, increased stunted forms, increased fetal deaths, decreased neonatal survival) in rats, mice and rabbits at doses of from 3 to 10 times the maximum recommended human dose. In pregnant monkeys, doses 2/3 and twice the maximum recommended human dose resulted in small placentas and underdeveloped chorionic villi. In rats, doses three times the maximum human dose and higher caused prolongation of pregnancy. There are no adequate and well-controlled studies in pregnant women. PROCARDIA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**ADVERSE REACTIONS:** In multiple-dose U.S. and foreign-controlled studies in which adverse reactions were reported spontaneously, adverse effects were frequent but generally not serious and rarely required discontinuation of therapy or dosage adjustment. Most were expected consequences of the vasodilator effects of PROCARDIA.

Adverse Effect	PROCARDIA (%) (N = 226)	Placebo (%) (N = 235)
Dizziness, light-headedness, giddiness	27	15
Flushing, heat sensation	25	8
Headache	23	20
Weakness	12	10
Nausea, heartburn	11	8
Muscle cramps, tremor	8	3
Peripheral edema	7	1
Nervousness, mood changes	7	4
Palpitation	7	5
Dyspnea, cough, wheezing	6	3
Nasal congestion, sore throat	6	8

There is also a large uncontrolled experience in over 2100 patients in the United States. Most of the patients had vasospastic or resistant angina pectoris, and about half had concomitant treatment with beta-adrenergic blocking agents. The most common adverse events were the same ones seen in the controlled trials, with dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients. Transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antihypertensive medication. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

Several of these side effects appear to be dose related. Peripheral edema occurred in about one in 25 patients at doses less than 60 mg per day and in about one patient in eight at 120 mg per day or more. Transient hypotension, generally of mild to moderate severity and seldom requiring discontinuation of therapy, occurred in one of 50 patients at less than 60 mg per day and in one of 20 patients at 120 mg per day or more.

In addition, 2% or fewer of patients reported the following: **Respiratory:** Nasal and chest congestion, shortness of breath. **Gastrointestinal:** Diarrhea, constipation, cramps, flatulence. **Musculoskeletal:** Inflammation, joint stiffness, muscle cramps. **CNS:** Shakiness, nervousness, jitteriness, sleep disturbances, blurred vision, difficulties in balance. **Other:** Dermatitis, pruritus, urticaria, fever, sweating, chills, sexual difficulties.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

In a subgroup of over 1000 patients receiving PROCARDIA with concomitant beta blocker therapy, the pattern and incidence of adverse experiences was not different from that of the entire group of PROCARDIA treated patients (see **Precautions**).

In a subgroup of patients with a diagnosis of congestive heart failure as well as angina, dizziness or light-headedness, peripheral edema, headache or flushing each occurred in one in eight patients. Hypotension occurred in about one in 20 patients. Syncope occurred in approximately one patient in 250. Myocardial infarction or symptoms of congestive heart failure each occurred in about one patient in 15. Atrial or ventricular dysrhythmias each occurred in about one patient in 150.

**Laboratory tests:** Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have already been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

**OVERDOSAGE:** Although there is no well documented experience with PROCARDIA overdosage, available data suggest that gross overdosage could result in excessive peripheral vasodilation with subsequent marked and probably prolonged systemic hypotension. Clinically significant hypotension due to PROCARDIA overdosage calls for active cardiovascular support including monitoring of cardiac and respiratory function, elevation of extremities, and attention to circulating fluid volume and urine output. A vasoconstrictor (such as norepinephrine) may be helpful in restoring vascular tone and blood pressure, provided that there is no contraindication to its use. Clearance of PROCARDIA would be expected to be prolonged in patients with impaired liver function. Since PROCARDIA is highly protein-bound, dialysis is not likely to be of benefit.

**DOSE AND ADMINISTRATION:** The dosage of PROCARDIA needed to suppress angina and that can be tolerated by the patient must be established by titration. Excessive doses can result in hypotension.

The starting dose is one 10 mg capsule, swallowed whole, 3 times/day. The usual effective dose range is 10–20 mg three times daily. Some patients, especially those with evidence of coronary artery spasm, respond only to higher doses, more frequent administration, or both. In such patients, doses of 20–30 mg three or four times daily may be effective. Doses above 120 mg daily are rarely necessary. More than 180 mg per day is not recommended.

In most cases, PROCARDIA titration should proceed over a 7–14 day period so that the physician can assess the response to each dose level and monitor the blood pressure before proceeding to higher doses.

If symptoms so warrant, titration may proceed more rapidly provided that the patient is assessed frequently. Based on the patient's physical activity level, attack frequency, and sublingual nitroglycerin consumption, the dose of PROCARDIA may be increased from 10 mg t.i.d. to 20 mg t.i.d. and then to 30 mg t.i.d. over a three-day period.

In hospitalized patients under close observation, the dose may be increased in 10 mg increments over four to six-hour periods as required to control pain and arrhythmias due to ischemia. A single dose should rarely exceed 30 mg.

No "rebound effect" has been observed upon discontinuation of PROCARDIA. However, if discontinuation of PROCARDIA is necessary, sound clinical practice suggests that the dosage should be decreased gradually with close physician supervision.

**Co-Administration with Other Antihypertensive Drugs:** Sublingual nitroglycerin may be taken as required for the control of acute manifestations of angina, particularly during PROCARDIA titration. See **Precautions, Drug Interactions** for information on co-administration of PROCARDIA with beta blockers or long-acting nitrates.

**HOW SUPPLIED:** Each orange, soft gelatin PROCARDIA Capsule contains 10 mg of nifedipine. PROCARDIA Capsules are supplied in amber glass bottles of 100 capsules (NDC 0069-2600-66). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

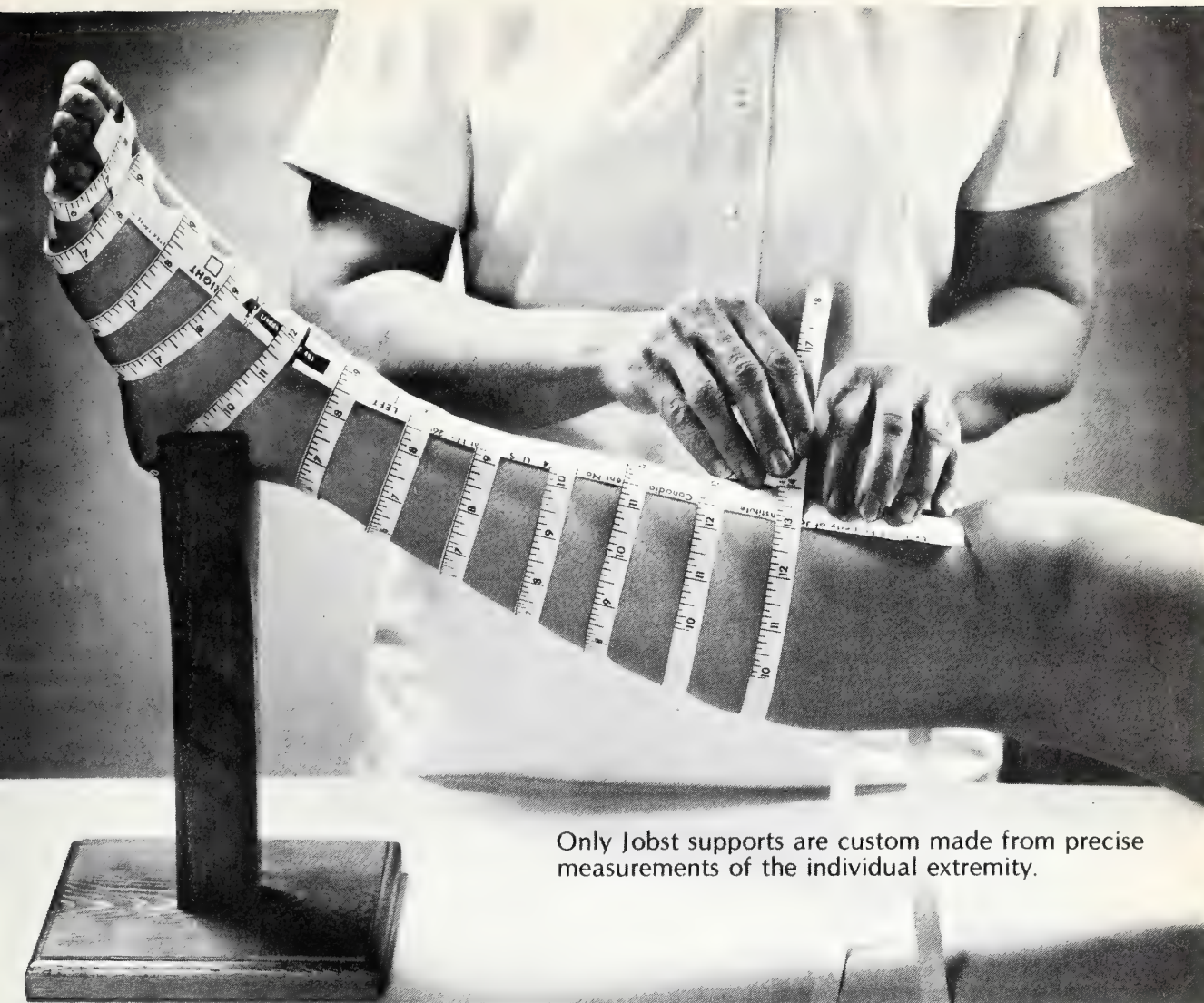
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# IMJ

*Illinois Medical Journal*

Volume 161, No. 3, March 1982

## *Part of a Functional Medical Curriculum*

### *Rehabilitation Medicine*

BY EUGENE J. ROGERS, M.D., F.A.C.P./NORTH CHICAGO

*The increasing number of undergraduate and graduate training programs in the health care field have significantly improved both acute and tertiary care resources. The chronically ill and patients with disabilities resulting from trauma, acute diseases, and congenital and degenerative processes, are generally still inadequately cared for.*

*Curricula and training programs must be reviewed with more emphasis on the comprehensive interdisciplinary health care approach, on management of the chronically ill and disabled and techniques for attaining maximal functioning for all patients, whether acute or chronic.*

The Council on Medical Education of the AMA has commended strides in improved medical services.<sup>1</sup> It concludes that medicine has not fully responded to social changes and needs and that

the public is dissatisfied and critical of the health care delivered. The fragmented specialized medical school departments have, until now, functioned less than optimally on behalf of students and patients. That preliminary report further states that every physician needs the basic education to develop attitudes, knowledge and skills required for the *comprehensive care* of patients, irrespective of final specialization, ability to recognize various physical and emotional problems, and provide good medical services at a reasonable cost. If not acquired at the medical school level, it may never be acquired by some physicians. Resolution #84 presented at the July, 1980 meeting of the AMA House of Delegates, called for further study by the Council of Medical Education.

Governmental bodies, providers, and consumers of health care seek to alleviate dissatis-



**Eugene J. Rogers, M.D., F.A.C.P.,** is professor and chairman of the department of rehabilitation medicine, University of Health Sciences, Chicago Medical School. Board certified in physical medicine and rehabilitation,

Dr. Rogers is a member of the *IMJ* Editorial Board. He has held numerous professional positions, including chairmanship of the ISMS Committee on Workmen's Compensation and fellowship in the Academy of Occupational Medicine. Dr. Rogers is a recent recipient of the Chicago Medical School Distinguished Alumnus Award.



faction and allay criticism. The Kennedy/Schweiker bill (S2375) introduced in the last session of Congress proposes goal oriented grants to medical schools instead of capitation. Medical schools would receive \$250 per student if these students were exposed to two of the following critical areas—nutrition, geriatrics, rehabilitation, health care economics and health policies, or occupational and environmental health. The medical curriculum must be reviewed.

This paper suggests some short term objectives, goals and methods for discussion and greater collaborative evaluation of the medical undergraduate medical curriculum. Others may explore postgraduate health education, and the health care delivery system. Those study groups must include greater participation by educators, practicing physicians, other providers, consumers and interested groups.

## Problems

A 1975 random sample of ambulatory care cases indicated that 45% were for chronic diseases that lasted more than three months and 55% were for acute problems.<sup>2</sup> Only 2% of all ambulatory visits required hospitalization. A survey<sup>3</sup> of 1497 U.S. medical school graduates showed that 68% were in the primary care fields of family medicine, general practice, internal medicine, or pediatrics. Graduates of schools with rehabilitation medicine departments were providing some supervision to rehabilitation personnel, instructing the disabled patients and their families, about prophylactic, maintenance, and therapeutic programs, as well as assisting in the psychosocial adjustment after release from a hospital. Programs in rehabilitation medicine and its concept of comprehensive care have been decreasing in medical schools from 92% in 1963-64 to 72% in 1974-75 and the residency recruitment has progressively declined since 1969.<sup>4</sup> Some of the residency vacancies have been filled in the past by foreign medical school graduates. The number of foreign graduates and the number of rehabilitation medicine programs in medical schools offering comprehensive care education are, however, declining. Eighty percent of students at schools with compulsory courses in rehabilitation medicine recommended its clerkship rotation. That preference was outranked by only emergency department, medicine and pediatric rotations.<sup>5</sup> Medical students must have exposure to courses in preventing illness, disability or complications. In addition to the classic acute and tertiary care principles, they also need training in comprehensive and restorative care.

## The Functional Medical Curriculum

Medical education must prepare physicians to deal comfortably and effectively with the concept of global medicine and its social implications. These include cost containment, quality assurance, the concept of team care and the increasing role of hospital administration.<sup>6</sup> Spilman and Spilman<sup>7</sup> investigated student, intern and resident perceptions of the relevancy of various basic science courses. Their findings of maximum relevance with physiology, pathology, and pharmacology indicated that the more clinical the basic science orientation and its correlation, the greater was its perceived relevance. Educators should review objectives and contents of current basic and clinical courses, since scientists and physicians have improved the quality of care for acute and crisis patients, but have not met society's comprehensive care expectations.

Patients need access to a physician who can provide continuing care and guidance, who will manage most of the illness and refer patients to sophisticated specialty care as needed. Medical schools must emphasize enhanced capability to provide comprehensive care irrespective of final specializations. They must provide a broader base of attitude, knowledge and skill for comprehensive care. The ability to recognize various physical and emotional problems; and effect medical services of benefit to patients at a reasonable cost is essential.<sup>1</sup> Educators concerned with problem solving must set short term and longer term educational goals to meet the needs of society. Primary responsibility for all health care will continue with the primary or treating physician, but patient, family, allied health care team members, agencies and others will be concerned and progressively involved. Patients are no longer passive recipients of health care. They are increasingly involved in improving, maintaining and restoring their health and function.

The major goals of medical education for our future physicians must include *improved skills in communication and interpersonal relations* with recipients of care, their families, the health care team and agencies. Establishing expertise in *preventive and health maintenance programs*, students must be able to problem solve, diagnose and appropriately treat all patients and refer when necessary. They must be *competent in triage* methods for life saving, evaluation and referral for tertiary care beyond the screener's expertise. Students must *develop comprehensive health care concepts* which emphasize not only clinical entities but patients as living, functioning individ-

uals who may require various resources to restore maximum abilities commensurate with their capacities. A cursory *overview of tertiary care* techniques and procedures is sufficient for orientation.

Medical schools, specialty societies, organized medicine and others have the academic expertise, facilities and personnel for the longer term goals of tertiary care training, pertinent continuing medical education, patient instruction and orientation for various audiences, agencies and other health care members. Planning, implementing and measuring the quality and the quantity of health care delivered must similarly be a collaborative effort.

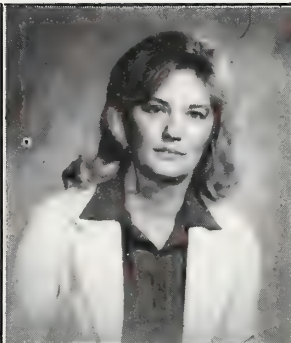
### Summary

A 1980 preliminary report by the AMA Council on Medical Education deplored the present inability of medical care to meet the needs of society. Committees were suggested to develop attitudes, knowledge and skills required for comprehensive care of patients. Rehabilitation medicine has taught these principles of comprehensive care for decades, but has not received adequate support, encouragement and status from organized medicine, physicians or health educators. Some objectives for short-range health care de-

livery were enumerated for the undergraduate medical curriculum. Task forces are also suggested for the long-range goals of tertiary care, continuing education, quality and quantity of health care delivered and education of professional and lay individuals for enlarging the responsibility in improving, maintaining and restoring health. ◀

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# Case Reports

## *An Unusual Left Upper Quadrant Mass*

### **Giant Mucocele of the Appendix**

BY BOHDAN K. WASILJEW, M.D. AND JAMES V. APOSTOL, M.D., MASON CITY, IOWA AND CHICAGO

*A giant mucocele of the appendix was encountered in a 60 year old man and is one of the largest recorded. This mucocele had an unusual clinical presentation as an asymptomatic left upper quadrant abdominal mass.*

A small mucocele of the appendix is found in approximately one of 300 routine appendectomies. Larger mucoceles produce *right lower quadrant* abdominal symptoms and signs, commonly chronic pain or a palpable mass. The only helpful diagnostic aid is barium enema, if it shows a characteristic defect in the cecum. The diagnosis is seldom made preoperatively. A mucocele is usually 4-6cm. in diameter and rarely reaches 15cm. This case report describes a mucocele which presented as a *left upper quadrant* abdominal mass and which also appears to be the second largest recorded mucocele.

A 60-year-old white man came to the out-patient department for evaluation of recently noted hypertension. He was admitted to the hospital when a large asymptomatic abdom-

inal mass was discovered during routine physical examination. Medical and surgical history, as well as review of systems, were unremarkable.

Pertinent physical findings included a blood pressure of 150/100 and a smooth, oval 20x30cm. left upper quadrant mass which extended across the midline and below the umbilicus. The mass was not pulsatile, tender, or movable. The liver and spleen were distinct from the mass and felt normal.

Routine laboratory tests were normal. Serum amylase was not elevated. Plain film of the abdomen revealed a large mass with a rim of calcification at its inferior border. An upper gastrointestinal series revealed that the mass displaced the stomach superiorly and the small bowel to the right. Barium enema revealed cen-

trifugal displacement of the left colon by a central mass with internal echoes, not related to kidneys or spleen. An abdominal arteriogram showed an avascular mass without displacement of retroperitoneal vessels. Based upon these results, the pre-operative diagnosis was an intraperitoneal cystic mass, probably a mesenteric cyst.

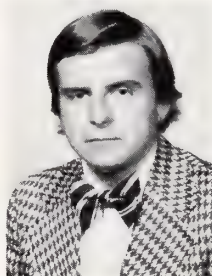
At the time of laparotomy, a large cystic mass was found attached to the cecum at the end of the anterior taenia, (Figure 1). This was clearly a giant mucocele of the appendix. The surface of the mass was grayish-white and the walls were thick with spots of calcification. It was removed easily without spillage. The specimen measured 29x20x20cm. and weighed 5kgs. Histologic examination confirmed the diagnosis. A small hyperplastic polyp was found at the base of the appendix, possibly the cause of the mucocele. There were no malignant cells in the specimen and no evidence of pseudomyxoma peritonei. The patient made an uneventful recovery.

#### **Discussion**

A mucocele of the appendix was first described by Von Rokitsky in 1842. The term mucocele was first used by Fere in 1877. Since the turn of the century, hundreds of mucoceles have been described. Mucoceles have been reported in patients rang-

**BOHDAN K. WASILJEW, M.D.**, is a surgeon in group practice affiliated with St. Joseph Mercy Hospital and North Iowa Medical Center in Mason City, Iowa. At this writing, Dr. Wasiljew was chief in surgery at Northwestern-McGaw Medical Center and an instructor in surgery at Northwestern University Medical School.

**JAMES V. APOSTOL, M.D.**, is a board certified general surgeon affiliated with Northwestern Memorial Hospital in Chicago. Dr. Apostol is also an assistant professor of surgery at Northwestern University Medical School and attending surgeon at Northwestern Memorial Hospital and the Veterans Administration Lakeside Medical Center.



ing from 16 to 89 years of age. The average age is 55-59 years.<sup>1</sup> They are said to occur more frequently after age 35 because of appendiceal lumen obliteration. There are conflicting reports on male or female predominance.

The dominant complaint is right lower quadrant abdominal pain, often chronic, seen in up to 64% of patients. Almost 23% of patients were totally asymptomatic. More unusual complaints include abdominal swelling, anemia, or a mucous fistula. Typical physical findings include right lower quadrant tenderness in 38% and a palpable mass in 18%-50%.<sup>2</sup> A left upper quadrant mass, as seen in our patient, is most unusual, having been reported only once previously.<sup>3</sup>

Laboratory studies may record leukocytosis if the mucocoele is associated with an inflammatory process. Profound anemia has been reported.<sup>4</sup> Barium studies may demonstrate a spherical, mobile, soft tissue mass displacing the cecum without filling of the appendix, and may suggest the correct diagnosis. Calcification in the wall of the mucocoele, as noted in our patient, is seen occasionally.<sup>5</sup> Rarely, it may be so heavy and extensive that the mucocoele may fracture, producing an acute abdomen.<sup>6</sup> Even with the aid of angiography, ultrasonography and colonoscopy, the diagnosis is rarely made preoperatively.

Most mucocoeles range from 3 to 6 cm. in diameter. The one in this case report is the second largest ever described. Rockus, in 1946, reported a specimen measuring 39x15 cm. and Andrews, *et al.*, in 1966, found one measuring 21.5x15 cm.<sup>7</sup>

Mucocoeles are caused by a triad of conditions which include obstruction of the appendiceal lumen, sterility of distal contents, and continued secretory activity. Obstruction may be of two types, benign and malignant. The ratio is 4-10:1 benign predominance. Benign causes of obstruction include fibrosis, inflammatory stricture, fecolith, hyperplastic polyp and mucinous cystadenoma. Obstructive endometriosis was reported in 1977.<sup>8</sup> Among malignant causes, carcinoma of the cecum, carcinoma of the appendix, carcinoid, and mucinous cystadenocarcinoma have been recorded.



**Figure 1**  
Operative photograph showing a giant mass delivered out of the wound with its attachment to the cecum.

Pseudomyxoma peritonei may be produced both by mucinous cystadenoma and cystadenocarcinoma, but it is only the malignant variant that retains the capabilities of invasion and spread within the peritoneal cavity after the appendix has been removed. The treatment of a simple mucocoele is appendectomy. In malignant cases where cecum or ileum are involved, a right hemicolectomy is indicated. Any mucinous material from the peritoneal cavity must be removed and searched microscopically for malignant cells. Intraperitoneal radioactive gold and peritoneal irrigation with nitrogen mustard have both been used with some success in small numbers of patients.<sup>9</sup>

The prognosis for patients with benign mucocoeles is excellent, with survivals of 100% reported. A 25% five year survival has been recorded for patients with malignant mucocoeles. ◀

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# Medical Student Section in Action

## HMOs and IPAs

BY JOSEPH M. HUGHES, MSS REPRESENTATIVE, ISMS COUNCIL ON ECONOMICS

*This article is based, in part, upon an educational slide presentation developed by the Council on Economics. Additional sources included publications of the American Medical Association, the U.S. Department of H.E.W. and the California Medical Association Commission on Medical Sciences. A complete bibliography is available upon request.*

Tremendous increases in health care costs have occurred in recent years. Over the decade from 1966 to 1976, health care costs in the U.S. rose from \$42 to \$137 billion. Only half of this growth can be attributed to general price inflation. More specifically, the percentage of the GNP devoted to health care has risen steadily over recent years from 8.6% in 1978 to approximately 11% in 1981.

As this problem has grown, so too have the number of proposed solutions. Health Maintenance Organizations, HMOs, are not new. The forerunner of the modern HMO was born in 1929 when Doctors Ross and Loos contracted with the city of Los Angeles to provide health care for certain employees for a predetermined fee. This was followed by the birth of the Kaiser-Permanente plan in 1938. Today this plan enrolls 3 million people in six states. Government involvement in this area began in 1970, when the Nixon administration targeted the containment of health care costs as a major objective.

In December of 1973, Public Law 93-222 (the "HMO Act") was signed into law. It defined an HMO as an organized, fiscally sound, legal entity, which provides, and/or arranges for a comprehensive range of medical benefits, including physician services and hospitalization. These are available to its voluntarily enrolled members and their families, who make (or on whose behalf there is made) prearranged, prepaid fees on a periodic basis. The Act authorized the Department of Health, Education, and Welfare to support feasibility studies, planning and development activities, and initial operation of HMOs over a period of five years. These were funded through grants to public and private nonprofit organizations, loans, and loan guarantees.

In order to remove impediments to the growth of HMOs, Public Law 94-460 was passed in Oct., 1976. This law greatly loosened the federal qualifications for health maintenance organizations. These amendments also increased grants and liberalized certain loan and loan guarantee provisions. More recently, Public Law 95-559 extended authorization for appropriations through fiscal year 1981. It also allowed loans for the construction of ambulatory care facilities and established

a training program for HMO administrators and medical directors. In 1980, 236 HMOs were operating. The federal government supplied \$150 million in grants and \$200 million in loans from 1973 to 1980.

The 1973 HMO Act recognizes three modes of organization. The *staff HMO* employs its own physicians on a salaried basis. The *group HMO* consists of participating physicians as part of a separate legal entity that contracts to provide services to enrollees in a clinic owned and operated by the HMO. These physicians are often permitted to serve non-HMO patients. The third type of HMO is the *Individual Practice Association*, or IPA. The physicians under contract to an IPA practice out of their own offices. The IPA physician can see both HMO and non-HMO patients.

HMOs have been used by industry to reduce and predict health care costs; by hospitals to increase patient load, stabilize cash flow, and increase out-patient services and by physicians to increase the number of patients, emphasize ambulatory care, stabilize cash flow, simplify billing, retain patients attracted to other plans, and forestall National Health Insurance. Hospitals have opposed HMOs because of their decreased emphasis on in-patient care. Physicians have done so because of the financial risk, patient inability to choose his own physician, danger of financial pressures causing rationing of care or reduced services and consultations, possible physician dependence on an HMO for financial survival, risk of entrepreneurs coming into the health care field, possible decline in the quality of health care due to increased use of paramedical personnel, danger that guaranteed access will cause overutilization by patients, and the potential for government regulations that could lead to governmental control of medicine.

Both the AMA and ISMS advocate neutral public policy and fair market competition among all systems of delivery. No single pattern of health care delivery suits all patients and physicians. True choice is possible only with multiple systems. ◀

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Eugene Hoban .....	Third District	Fred Z. White .....	Fourth District
Ross Hutchison .....	Eleventh District	Cyril C. Wiggishoff .....	Third District
Eugene P. Johnson .....	Eighth District	Herman Wing .....	Third District
Ted LeBoy .....	Third District	Warren Young .....	Third District
A. Edward Livingston .....	Fifth District	Paul P. Youngberg .....	Fourth District
Paul F. Mahon .....	Fifth District		



# Delegates and Alternate Delegates to the Illinois State Medical Society

## DOWNSTATE DELEGATES

<i>County</i>	<i>Delegates</i>	<i>Alternate Delegates</i>
<b>District #1</b>		
KANE (4)	A. Beaumont Johnson Wayne Leimbach Francis Oslay George Shimkus	Kenneth Albrecht Robert Flanigan James C. Pritchard William Sheehy
LAKE (6)	Hugh Falls David Littman Eugene Pitts David Shapiro P. L. Vinciguerra	Albino Bismonte Homer Goldstein Richard K. Hawkins David S. Helberg Burton Miller
McHENRY	Arthur A. Woloshin August M. Rossetti	Robert Munson William Larsen
<b>District #2</b>		
BUREAU LASALLE LIVINGSTON MARSHALL-PUTNAM WOODFORD	Kent McQueen E. J. Fesco Dalisay Bello E. R. Resurreccion, Jr. Ronald Meyer	Louis Lukancic Richard Schmidt Gregorio Manabat Joe Cannon Hans Riggert
<b>District #4</b>		
FULTON HANCOCK HENDERSON HENRY-STARK KNOX McDONOUGH MERCER PEORIA (6)	Jack Gibbs C. F. Eddingfield Silvino C. Lindo Reinert Svendsen, Jr. Jerry Ramunis Richard Iverson Monty P. McClellan Ernest F. Adams Dean R. Bordeaux Lorris Bowers James DeBord Richard H. Lee Paul Norris	Rod Maguire James Coeur  James Parsons Irene Caruso Lawrence Kerr Mohamed Rajput Joseph Dean James E. Maher Tim C. Miller J. Kevin Paulsen John J. Taraska David E. Trachtenberg
ROCK ISLAND (3)	James F. Duesman Manuel O. Guerrero Richard Snodgrass	Charles Dyke Robert Lelonek Charles Pogue
SCHUYLER TAZEWELL WARREN	Robert E. Cox Robert M. Wright K. E. Ambrose	Henry C. Zingher Robert L. Tucker V. Arora

<i>County</i>	<i>Delegates</i>	<i>Alternate Delegates</i>
<b>District #5</b>		
DEWITT	S. Kolandaivelu	Robert E. Myers
LOGAN	Edward Ulrich	James Borgerson
MCLEAN (2)	Loren Boon	Robert E. Knight
	Robert Reardon	Wil Thielemann
	Jack Means	John W. McHarry, Jr.
MASON		
MENARD	Lee Johnson	
MONTGOMERY	Towfig M. Arjmand	John Dietrich
SANGAMON (5)	Edward G. Ference	Robert B. Dodd
	John Holland	Stefan Kozak
	Michael Snyder	Marion Panepinto
	Elvin Zook	Ronald Staubly
<b>District #6</b>		
ADAMS	Marvin Grote	Walter Stevenson, III
CASS-BROWN		
GREENE	Jose P. Parcon	Ludwig Dech
JERSEY-CALHOUN	Neal Gipson	Herman Wuestenfeld
MACOUPIN	Robert G. England	Anand Talcherkar
MADISON (3)	E. K. DuVivier	Robert F. Hamilton
	Melvin Freedman	Rosalyn Lepley
	George T. Wilkins	Edward Ragsdale
	Frank Norbury	Joseph Winterhalter
MORGAN-SCOTT	Carlos B. Lara	Ronald L. Johnson
PIKE		
<b>District #7</b>		
BOND	Boyd McCracken, Sr.	M. K. Kaufmann
CHRISTIAN	Edward D. Slifer	
CLAY		
CLINTON	Wilson L. DuComb	Michael Bateman
EFFINGHAM		
FAYETTE	Joshua Weiner	Hans Rollinger
MACON (2)	Randolph G. Emerson	S. Chadwick
	Delbert H. Hahn, Jr.	S. Goetter
	Richard Rudman	E. F. Stephens, III
MARION	Eugene J. Boros	Phillip Best
MOULTRIE	George G. Green	William E. Mundt
PIATT	Edwin J. Siroy	Urbano Daus
SHELBY		
<b>District #8</b>		
CHAMPAIGN (3)	Harlan Failor	Victor Feldman
	Jack Hull	Harold Kolb
	Arthur R. Traugott	Robert Welke
CLARK	Dorothy Hubler	Steven Macke
COLES-CUMBERLAND	Mack W. Hollowell	Joseph Mallory
CRAWFORD	Charles Salesman	Dean J. Pelley
DOUGLAS	Humberto Mondul	Robert N. Arrol
EDGAR	J. M. Ingalls	Duane Haskell
JASPER		
LAWRENCE	Gary D. Carr	Larry Herron
RICHLAND	Charles A. DeKovessey	Enrique Bouffard, III
VERMILION	Raja Sadiq	W. F. Hensold
<b>District #9</b>		
ALEXANDER	Gemo Y. Wong	Charles L. Yarbrough
EDWARDS		
FRANKLIN	James Durham	
GALLATIN	John E. Doyle	



<i>County</i>	<i>Delegates</i>	<i>Alternate Delegates</i>
JACKSON	Paul P. Lorenz	Eli L. Borkon
JEFFERSON-HAMILTON	Charles K. Wells	H. Goff Thompson
JOHNSON		
MASSAC	Enrique Y. Yap	Benito Bajuyo
PULASKI	A. L. Robinson	
SALINE-POPE-HARDIN	A. Z. Goldstein	Larry Jones
UNION	Thomas Davis	William Whiting
WABASH	E. Lowenstein	Roger Fuller
WAYNE	E. B. Loftin	
WHITE	Phillip Boren	
WILLIAMSON	Herbert V. Fine	Robert Kane

### **District #10**

MONROE	Russell W. Jost	E. F. Maglasang
PERRY	C. E. Cawvey	B. A. Kinsman
RANDOLPH	O. W. Pfisterer	Allan Liefer
ST. CLAIR (3)	Lloyd Thompson	Wallace Berkowitz
	Robert Wanless	Charles Frazer, Jr.
	Ronald Welch	Donald I. Serot
WASHINGTON	Gary A. Goforth	

### **District #11**

DUPAGE (10)	Peter Brusca	Anita Balodis
	James P. Campbell	Raymond A. Dieter, Jr.
	William B. Frymark	Robert D. Dooley
	Joseph P. McKay	Willard Elyea
	Morgan M. Meyer	Robert Fitzgerald
	Joseph R. O'Donnell	William P. Gibbons
	William C. Perkins	Sharon Pelton
	Garth Smith	Erlo Roth
	Thomas W. Stach	Ronald M. Severino
	Harold Walgren	
FORD	Ross Hutchison	Somchai Supawanich
IROQUOIS	R. K. Swedlund	J. E. Dailey
KANKAKEE	Donald Parkhurst	H. P. Swartz
KENDALL	Walter H. Brill	Michael R. Saxon
WILL-GRUNDY (4)	Robert J. Becker	Van L. Hicks
	Albert W. Ray, Jr.	Kenneth P. Jesunas
	Stanley Rousonelos	Theodore Kanellakes
	Kenneth M. Uznanski	John D. Walter

### **District #12**

BOONE	Earl Davis	Kent Hess
CARROLL	Benjamin Sy	C. G. Piper
DEKALB	John W. Ovitz, Jr.	Dean Miller
JO DAVIESS	Francis Waites	Delbert Williams
LEE	Donald Edwards	Kyu Jin Cho
OGLE	Don E. Hinderliter	Vincenzo Traina
STEPHENSON	William H. Isham	F. H. DesCourouez
WHITESIDE	John Hubbard	Girish R. Bhatt
WINNEBAGO (5)	Robert Behmer	Gareth Eberle
	Raymond Hoffmann	Robert Bertrand
	William Kobler	John Leonard
	F. H. Riordan, III	Warren Lowry
	Jerome Weiskopfe	Daniel Swift

### **Medical Student Section Resident Physicians Section**

Ronald Davis	Malcolm Major
William E. Golden	John Hall

## COOK COUNTY DELEGATES

<i>Delegates</i>	<i>Alternate Delegates</i>	<i>Delegates</i>	<i>Alternate Delegates</i>
Aaronson, Donald Andelman, Samuel L. Andersen, James H. Armstrong, Clara Bartolome, Juanito Berg, Max	Ahstrom, James, Jr. Banuchi, Fedor F. Beck, Charles A. Becker, Frank O. Bellows, Randall Bihl, John	Murray, Meredith B. Nemecek, Raymond W. Neskodny, J. F. Odiaga-Garcia, Ignacio O'Sullivan, Donal D. Okner, Henry B.	Nikurs, Lydia Nosal, Roger Nourbakhsh, M. Olen, Richard N. Olivar, Adriano Palmer, Arthur
Bhorade, Maruti S. Blankshain, Richard Bogen, Gilbert Bragman, Robert Branovacki, Eugene Brislen, Andrew J.	Borelli, Nelson Brown, Finley, Jr. Brown, Murray C. Budrys, Milda Burdick, Allison L., Jr. Burdick, Allison L., Sr.	Ostrowski, Fabian Pamintuan, Rodolfo L. Panayotou, Irene Perritt, Richard Peterson, Arthur R. Petty, David T.	Panton, John H. Pantone, Anton M. Pill, Michael P. Podzamsky, George Poma, Pedro A. Pruc, Jeremias N.
Budrys, Stanley Burkhead, Howard C. Ciskoski, Ronald J. Coleman, John M. Costanzo, Vincent A. Cross, Roland R.	Burke, Edward A. Carroll, Catherine G. Chaljub, Najib Christensen, Eldis M. Christou, Anastase A. Cucco, Ulisse P.	Quinlan, Donald Razim, Edward A. Rice, C. Malcolm, Jr. Romanus, Raymond J. Rothstein, David A. Ruzich, Stanley	Rezvan, A. Richardson, James M. Rodriguez, Alberto E. Rodriguez, Ignacio Saltiel, Isaac Sarley, Vincent
Czeisler, Tibor Danckers, Ulrich F. DeJong, George A. Diffenbaugh, W. G. Driscoll, John E. Elward, Kurtis	DeTrana, Frank E. DiMarco, Eugene R. Doyharzabal, Roger Elegant, Lawrence D. Fabian, Sydney Feldman, Sydney	Santos, Antonio Saulys, Augusta Z. Schifano, Joseph Schimel, Samuel J. Sedlak, Frank Seed, Randolph	Saulys, Vacys Schall, Samuel M. Schuetz, John N. Schwartz, Malcolm Schwartz, Sheldon D. Seglin, Melvin N.
Fagan, Peter T. Falloon, Edwin L. Farah, George S. Fish, William FitzGibbons, James P. Flaherty, B. P.	Filipowicz, Roman I. Forgione, Hebe M. Friedell, Peter E. Gianasi, Charles Gnade, Gerard R. Goodman, Harold	Simon, Arnold Sinaiko, Edwin S. Smith, C. Otis Soboroff, Burton J. Solon, Earl N. Springer, Harry	Senno, Aref Short, Marshall Siedentop, Karl H. Smith, William S. Sprang, Milton L. Stockhammer, Dan
Flanagan, C. Larkin Frankel, Jerome J. Gertz, George Gonzales, Martin Green, Martin W. Guerrero, Severo K., Jr.	Gorday, Rose I. Graham, James Gueyikian, Berj Gutierrez, Antonio Handler, Jerome L. Harrod, John	Staley, Warren H. Stephens, Natalie Suckow, Earl E. Sugar, Sam J. Swartz, Robert M. Tansey, William J.	Strohl, Lee H. Study, Robert S. Sultan, Thomas R. Sutoris, Edward D. Talso, Peter J. Thampy, Kishore J.
Harwood, Thomas P. Hinkamp, Joseph F. Hoban, Eugene Hoeltgen, Maurice Horton, Loren B. Hrejsa, Allen J.	Jensen, Harold Johnson, M. Anita Jones, Richard Keer, Larry M. Keifer, John W. Knudson, John A.	Tekdogan, Mehmet M. Thompson, J. Robert Tovar, Jorge Triester, Michael R. Ungar, Jacob Vega, Jesus	Tobin, John T. Zitek, Russell W.
Hughes, Joseph Hutchinson, William A. Hyde, John S. John, Thomas Joslyn, A. Everett, Jr. Kahn, Sidney C.	Konecny, Philip Landau, Richard L. Lipsich, Michael Lucina, Pedro A. Markoutsas, George C. Mason, John W.	Walkowiak, Lydia Wehrmacher, Wm. H. Williams, Jack Zurita, Victor	
Kalsch, Harry E. Kaz, Alex H. Kirschenbaum, M. Barry Kobak, Mathew Kwinn, Frank C. Lagorio, George L.	McCabe, Mary Joan Meccia, Donald Meyenberg, John Mikhail, Kamel A. Modi, C.M. Mohr, Dorothy P.		
Libman, Robert H. Lobraico, Rocco V., Jr. Lukaszewski, Edwin J. MacNerland, Robert H. Marshall, William Miller, Russell	Mostowfi, Kiumars Munoz, Maria Muriel, Hugo H. Mustell, Robert R. Neumann, Helen A. Nicholas, Everett E.		



# Officers of County Medical Societies 1982

COUNTY	PRESIDENT	SECRETARY
ADAMS Members: 105-Dist. 6 Maxine Boyer, Ex. Sec. 1118 Broadway Quincy 62301	Randall McClelland 1888 Main, Quincy 62301	Richard L. Newman 1124 Broadway, Quincy 62301
ALEXANDER Members: 10-Dist. 9	Gemo Wong 529 Cross, Cairo 62914	Charles L. Yarbrough 800 Commercial, Cairo 62914
BOND Members: 9-Dist. 7	Thomas D. Dawdy 100 N. Locust, Greenville 62246	Boyd A. McCracken 100 N. Locust, Greenville 62246
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BUREAU Members: 40-Dist. 2	Merle Piacenti 600 E. 1st St., Spring Valley 61362	Swasdi Pothikamjorn 4040 Progress Blvd., Peru 61354
CARROLL Members: 8-Dist. 12	Benjamin Sy Savanna Medical Center, Savanna 61074	Basilios Lambos 101 Broad St., Lanark 61046
CASS-BROWN Members: 1-Dist. 6		
CHAMPAIGN Members: 230-Dist. 8 Larry Booth, Ex. Sec. 1408 W. University Urbana 61801	Robert E. Welke 602 W. University, Urbana 61801	Paul W. Yardy 602 W. University, Urbana
CHRISTIAN Members: 26-Dist. 7	Deogracias F. Quizon 217 S. Locust, Pana 62557	I. Del Valle 311 S. Main, Taylorville 62568
CLARK Members: 6-Dist. 8	George T. Mitchell Cork Medical Center, Marshall 62441	Eugene P. Johnson P. O. Box 68, Casey 62420
CLAY Members: 7-Dist. 7	Donald L. Bunnell Flora Clinic, Flora 62839	Eugene Foss P.O. Box 250, Flora 62839
CLINTON Members: 12-Dist. 7	Michael A. Bateman 541 Ninth St., Carlyle 62231	James A. Kirby 401 N. Main, Breese 62230
COLES-CUMBERLAND Members: 55-Dist. 8	Asu Basu 921 Eighteenth St., Charleston 61938	J. Ben Mallory Sarah Bush Lincoln Health Center, Mattoon 61938
COOK Members: 8498-Dist. 3 Fred Schwartz, Exec. Dir. 515 N. Dearborn St. Chicago, IL 60610	Robert C. Hamilton 25 E. Washington, Chicago 60602	Richard H. Blankshain 715 Lake St., Oak Park 60301
CRAWFORD Members: 11-Dist. 8	Frank Gross 1002 Allen, Robinson 62454	W. B. Schmidt Schmidt Clinic, Robinson 62454
DEKALB Members: 63-Dist. 12	Thomas Kirts 232 S. Second St., DeKalb 60115	William F. Stach 407 W. State St., Sycamore 60178
DEWITT Members: 10-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
DOUGLAS Members: 7-Dist. 8	Robert N. Arrol 126 S. Locust, Arcola 61910	Grant A. Jones 318 S. Ash, Arthur 61911

COUNTY	PRESIDENT	SECRETARY
DUPAGE Members: 707-Dist. 11 Lillian Widmer, Ex. Sec. 26 W. St. Charles Rd. Lombard, IL 60148	Peter A. Brusca 503 Thornhill Dr., Carol Stream 60187	James P. Campbell 322 N. Blanchard St., Wheaton 60187
EDGAR Members: 15-Dist. 8	Duane Haskell 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
EFFINGHAM Members: 16-Dist. 7	P. D. L. Nayak 401 N. Mulberry St. Effingham 62401	P. D. L. Nayak 401 N. Mulberry St. Effingham 62401
FAYETTE Members: 7-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Vasudev Kachgal 802 N. Eighth St., Vandalia 62471
FORD Members: 11-Dist. 11	George Elfers Bellflower 61724	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
FRANKLIN Members: 30-Dist. 9	Talivaldis Kisle 502 W. Franklin, Sesser 62884	R. G. Thompson 309 W. St. Louis St., W. Frankfort 62896
FULTON Members: 40-Dist. 4	Jessie M. Reyes 210 W. Walnut, Canton 61520	Thomas C. Schrepfer 511 Promenade, Havana 62644
GALLATIN Members: 2-Dist. 9		John E. Doyle Ridgway 62979
GREENE Members: 6-Dist. 6	Jude A. Caselton 727 South 9th, Carrollton 62016	James C. Reid 712 S. College, Greenfield 62044
HANCOCK Members: 12-Dist. 4	Vasant Pawar Memorial Hospital, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
HENDERSON Members: 2-Dist. 4	Silvino Lindo, Jr. Biggsville 61418	Silvino Lindo, Jr. Biggsville 61418
HENRY-STARK Members: 36-Dist. 4	Randall L. Mullin 648 North Chicago, Geneseo 61254	Hipolito C. Lopez, Jr. 716 Elliott, Kewanee 61443
IROQUOIS Members: 20-Dist. 11	C. P. DeVas Gunawardhane PO Box 638, Clifton 60972	Jeffery Swider 106 Prof. Arts Bldg., Rts 1 & 24E Watseka 60970
JACKSON Members: 113-Dist. 9	Kevin K. Mooney 404 W. Main, Carbondale 62901	Teri G. Monk 404 W. Main, Carbondale 62901
JASPER Members: 2-Dist. 8	Monico Low 609 S. Van Buren, Newton 62448	Juan J. Serra 507 W. Washington, Newton 62448
JEFFERSON-HAMILTON Members: 37-Dist. 9	H. Goff Thompson 1708 Jefferson, Mt. Vernon 62864	Kenneth Peart #1 Doctors Park, Mt. Vernon 62864
JERSEY-CALHOUN Members: 10-Dist. 6	Abbas Assar 122 E. Bridgeport, White Hall 62092	Bernard Baalman Medical Center, Hardin 62047
JO DAVIESS Members: 9-Dist. 12	David Hockman 300 Summit St., Galena 61036	Wilbur Johnson 300 Summit St., Galena 61036
KANE Members: 320-Dist. 1 H. Michael Wild, Ex. Dir. 355 First St. Batavia 60510	John A. O'Dwyer 34 N. Water, Batavia 60510	Nasir Jamal Ahmad 296 W. Spring St., So. Elgin 60177
KANKAKEE Members: 111-Dist. 11	Ray R. Schale 475 W. Merchant St., Kankakee 60901	Charles F. Lind 500 W. Court St., Kankakee 60901



COUNTY	PRESIDENT	SECRETARY
KENDALL Members: 8-Dist. 11	Walter Brill Main St., Oswego 60543	John P. Cullinan Oswego 60543
KNOX Members: 82-Dist. 4 Mrs. Jane Gau, Exec. Sec. Galesburg Cottage Hospital 695 N. Kellogg Galesburg, IL 61401	Homer L. Fleisher, Jr. 904 East Main, Knoxville 61448	Martin D. McDermott 555 N. Kellogg, Galesburg 61401
LAKE Members: 415-Dist. 1 Julia Schultz, Ex. Sec. P.O. Box 148 Gurnee, Ill. 60031	Edward Leslie 935 Glen Flora, Waukegan 60085	David Shapiro 704 Paddock La., Libertyville 60048
LASALLE Members: 102-Dist 2	James B. Aplington 206 Marquette St., LaSalle 61301	Allan L. Goslin 712 N. Bloomington, Streator 61364
LAWRENCE Members: 13-Dist. 8 Ruth E. Garipey, Ex. Sec. Lawrence Cty. Mem. Hosp. Lawrenceville 62439	Robert J. Nichols P.O. Box 907, Vincennes, Ind. 47591	Francisco E. Martin 542 N. Main, Bridgeport 62417
LEE Members: 24-Dist. 12	Michael C.K. Hong 403 E. First St., Dixon 61021	Tiam H. Lie Rt. 5 Castellan, Dixon 61021
LIVINGSTON Members: 27-Dist. 2	Gregorio M. Manabat 612 E. Water, Pontiac 61764	Karl T. Deterding 612 E. Water, #109, Pontiac 61764
LOGAN Members: 25-Dist. 5	Steven D. Kottemann 311 8th St., Lincoln 62656	Wayne J. Schall 311 8th St., Lincoln 62656
MACON Members: 163-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur 62521	Giles Richard Locke 2300 N. Edward, Decatur 62521	H. Gale Zacheis 2220 N. Monroe, Decatur 62526
MACOUPIN Members: 19-Dist. 6	Anand Talcherkar 116 South Plum, Carlinville 62626	Robert England 935 Morgan, Carlinville 62626
MADISON Members: 208-Dist. 6	James W. Sanders 1538 East Troy, Edwardsville 62025	Norman E. Taylor 95 S. 9th St., E. Alton 62024
MARION Members: 44-Dist. 7	Mary K. Markle 1201 E. Broadway, Centralia 62801	W. P. Plassman Box 552, Centralia 62801
MARSHALL-PUTNAM Members: 3-Dist. 2	Donald M. Gallagher Box 538, Granville 61326	Joe W. Cannon, M.D., Secretary 202 South Main, Lacon 61540
MASON Members: 5-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	Henry W. Maxfield 315 E. Chestnut, Mason City 62664
MASSAC Members: 3-Dist. 9	Enrique T. Yap 510 W. 10th St., Metropolis 62960	Benito Bajuyo P.O. Box 187, Metropolis 62960
MCDONOUGH Members: 30-Dist. 4	Edward K. Baker 505 East Grant, Macomb 61455	David Reem 505 E. Grant, Macomb 61455
MCHEHRY Members: 78-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Woodstock 60098	Richard Gorski 71 Judd St., McHenry 60050	Robert E. Stanell 3516 W. Waukegan Rd., McHenry 60050
MCLEAN Members: 128-Dist. 5 Carol Toperzer, Exec. Sec. 1236 E. Empire Bloomington 61701	David L. Doud 900 Franklin, Normal 61761	John R. Krueger #1 Medical Hills Dr., Bloomington 61701

COUNTY	PRESIDENT	SECRETARY
MERCER Members: 5-Dist. 4	Monty P. McClellan 309 NW 2nd St., Aledo 61231	Dennis D. Palmer 409 NW Fourth, Aledo 61231
MONROE Members: 10-Dist. 10	Ingeborg M. Kremer 854 Bottom, Columbia 62236	Chong K. Park 415 W. South 4th, Red Bud 62278
MONTGOMERY Members: 20-Dist. 5	Walter R. Williams 1250 East Tremont, Hillsboro 62049	Roger Wujek Medical Arts Building 1225 E. Union, Litchfield 62056
MORGAN-SCOTT Members: 50-Dist. 6	Eric Giebelhausen 2001 West Morton, Jacksonville 62650	John Peterson 400 Farmers Bank Building, Jacksonville 62650
MOULTRIE Members: 4-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951
OGLE Members: 16-Dist. 12	L. T. Koritz 324 Lincoln, Rochelle 61068	Russell Zack 915 Caron, Rochelle 61068
PEORIA Members: 419-Dist. 4 M. John Hanni, Jr., Ex. V.P. 427 1st National Bank Bldg. Peoria 61602	Gene O. Hoerr 427 1st National Bank Bldg., Peoria 61602	Frederick Heinzen 427 1st Nat'l. Bank Bldg., Peoria 61602
PERRY Members: 15-Dist. 10	Gene Stotlar 13 N. Walnut St., Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
PIATT Members: 4-Dist. 7	George Green 1111 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
PIKE Members: 11-Dist. 6	B. J. Rodriguez 868 Mortimer, Barry 62312	Carlos B. Lara 326 W. Washington, Pittsfield 62363
PULASKI Members: 1-Dist. 9	A. L. Robinson Box 277, Mounds 62964	
RANDOLPH Members: 20-Dist. 10	Allan L. Liefer 415 W. S. Fourth, Red Bud 62278	J. M. Whittenberg 1650 State St., Chester 62233
RICHLAND Members: 24-Dist. 8	Don F. Hatten 408 N. Mill St., Olney 62450	Chandra Varadachari Richland Memorial Hosp., Olney 62450
ROCK ISLAND Members: 197-Dist. 4 James A. Koch, Ex. Sec. 612 Kahl Bldg. Davenport, Iowa 52801	Raymond F. Hillson 1520 7th Street, Moline 61265	Charles W. Koivun 1704 7th Avenue, Moline 61265
ST. CLAIR Members: 272-Dist. 10 Ed Belz, Ex. Sec. 6400 W. Main Belleville 62223	Ronald G. Welch 333 S. Illinois, Belleville 62220	Edward P. Rose 5308 W. Main, Belleville 62223
SALINE-POPE-HARDIN Members: 32-Dist. 9	Earl E. Walker 203 N. Vine St., Harrisburg 62946	Warren R. Dammers P.O. Box 281, Harrisburg 62946
SANGAMON Members: 402-Dist. 5 L. R. Brosi, Ex. Dir. 1 N. Old State Capitol Plaza Springfield 62701	Mir-Towfig M. Arjmand 329 S. New St., Springfield 62704	Michael C. Snyder 800 E. Carpenter, Springfield 62702
SCHUYLER Members: 4-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
SHELBY Members: 9-Dist. 7	P. D. Gurujal Shelby Cty. Med. Cntr., Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565



COUNTY	PRESIDENT	SECRETARY
STEPHENSON Members: 57-Dist. 12	Young Chung 3130 W. Stephenson, Freeport 61032	George Lagen 1045 W. Stephenson, Freeport 61032
TAZEWELL Members: 75-Dist. 4 Colleen Ingersoll, Exec. Sec. P.O. Box 778 Pekin 61554	Dennis F. Olson 2808 Court, Pekin 61554	Robert F. Gregorski P.O. Box 778, Pekin 61554
UNION Members: 12-Dist. 9	Thomas W. Davis 319 S. Main St., Anna 62906	Carroll O. Loomis Union County Hosp., Main St., Anna 62906
VERMILION Members: 113-Dist. 8	Edward N. Heatherington 715 W. Fairchild, Danville 61832	Michael Lomax 723 N. Logan, Danville 61832
WABASH Members: 5-Dist. 9	Ernest Lowenstein 1123 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863
WARREN Members: 14-Dist. 4	Kenneth E. Ambrose 219 E. Euclid, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
WASHINGTON Members: 6-Dist. 10	Ralph Kelley 113 W. St. Louis, Nashville 62263	Charles Longwell 111 S. Washington, Nashville 62263
WAYNE Members: 9-Dist. 9	A. R. Marks 101 E. Center Rd., Fairfield 62837	Eugene B. Loftin 301 N.W. Eleventh St., Fairfield 62837
WHITE Members: 8-Dist. 9	Phillip D. Boren Doctors Clinic, Carmi 62821	P. G. Ravindranathan Doctors Clinic, Carmi 62821
WHITESIDE Members: 53-Dist. 12	Girish R. Bhatt 101 E. Miller Rd., Sterling 61081	Shashi A. Patel 1601 First Ave., Sterling 61081
WILL-GRUNDY Members: 254-Dist. 11 Ronald W. Batozech, Ex. Sec. 3033 W. Jefferson Suite 220 Joliet 60435	Kenneth Jesunas 3077 W. Jefferson, Joliet 60435	Irving Rudman 1301 Copperfield, Joliet 60435
WILLIAMSON Members: 38-Dist. 9	M. T. Joseph 106 S. Vicksburg, Marion 62959	Herbert V. Fine 110 N. Division, Cartersville 62918
WINNEBAGO Members: 399-Dist. 12 Robert Carlson Exec. Adm. 310 N. Wyman St. Rockford 61101	Edward Sharp 5668 E. State, Rockford 61108	William E. Kobler 5670 E. State St., Rockford 61108
WOODFORD Members: 7-Dist. 2	Joe C. Phifer 203 South Main, Eureka 61530	James W. Riley 109 S. Major, Eureka 61530

#### No Organized County Society

Edwards  
Johnson  
Menard

#### Joint County Societies

Cass-Brown  
Coles-Cumberland  
Henry-Stark  
Jefferson-Hamilton  
Jersey-Calhoun

Marshall-Putnam  
Morgan-Scott  
Saline-Pope-Hardin  
Will-Grundy

# *Agenda*

## *1982 House of Delegates*

**Clifton L. Reeder, M.D., *Speaker***

**Julian W. Buser, M.D. *Vice-Speaker***

### **FIRST SESSION**

**9:30 a.m.—Friday, April 16, 1982**

**Red Lacquer Room**

**Palmer House**

**Chicago**

1. Call to order  
Clifton L. Reeder, M.D., *Speaker*
2. Invocation
3. Report of Committee on Rules and Order of Business
4. Report of Credentials Committee
5. Approval of minutes of previous meeting
6. Memorial Service for members deceased since April, 1981 conducted by Eugene P. Johnson, M.D., *Secretary-Treasurer*
7. Introduction of Special Guests
8. Report of Chairman, Board of Trustees  
Morris T. Friedell, M.D.
9. Remarks of Speaker
10. Resolutions and supplementary reports
11. New business and announcements  
Reference Committees—1:30 p.m.  
Delegates' Brunch—11:30 a.m.-1:30 p.m.
12. Recess until 9:30 a.m., Saturday, April 17, 1982

### **SECOND SESSION**

**9:30 a.m.—Saturday, April 17, 1982**

**Red Lacquer Room**

**Palmer House**

**Chicago**

1. Call to order by speaker
2. Report of Committee on Rules and Order of Business
3. Report of Credentials Committee
4. Reports of special guests  
Mrs. Harold Keegan, *President*, Illinois State Medical Society Auxiliary  
Mrs. Mary Lou Ostrowski, *President*, Illinois Society, American Association of Medical Assistants
5. Introduction of special guests
6. Presentation of certificates of appreciation to Continuing Medical Education Examiners
7. Presentation of AMA-ERF check to Illinois medical schools
8. IMPAC Report  
Paul Mahon, M.D., *Chairman*
9. Report of Executive Administrator  
Mr. Alexander R. Lerner
10. Introduction of AMA Delegates and Alternate Delegates  
Theodore Grevas, M.D., *Chairman*
11. President's Address  
Fred Z. White, M.D.
12. New business and announcements
13. Reports of Reference Committees
14. Recess until 2:00 p.m.
15. Call to order by the speaker
16. Reports of Reference Committees  
Amendments to Constitution and Bylaws  
Committee A—Officers, Administration, Finances and Budgets  
Committee B—Government Health Programs, including National Health Insurance and Cost Containment  
Committee C—Education, Manpower and Clinical Medicine  
Committee D—Medical Service and Economic Matters Outside of Government Programs  
Committee E—Governmental Affairs and Medical Legal  
Committee F—Public Relations, Membership and Miscellaneous Business
17. New Business
18. Recess until 9:00 a.m.—Sunday, April 18, 1982



**THIRD SESSION**  
**9:00 a.m.—Sunday, April 18, 1982**  
**Red Lacquer Room**  
**Palmer House**  
**Chicago**

1. Call to order by the Speaker
2. Report of Committee on Rules and Order of Business
3. Report of Credentials Committee
4. Induction of Cyril C. Wiggishoff, M.D., President-Elect, into office of President by Fred Z. White, M.D.
5. Address of President Wiggishoff
6. Announcements and introduction of guests
7. Reports of reference committees
8. Elections

*Report of Nominating Committee*

- (a) President-Elect (DS)
- (b) 1st Vice President (CMS)
- (c) 2nd Vice President (DS)
- (d) Secretary-Treasurer
- (e) Speaker of the House (CMS)
- (f) Vice Speaker (DS)
- (g) Trustees

*District Terms Expiring*

Third District Alfred Clementi, M.D.  
Jere Freidheim, M.D.  
Fourth District George Burke, M.D.  
Fifth District Robert Prentice, M.D.  
Seventh District Alfred J. Kiessel, M.D.  
Eighth District James Laidlaw, M.D.

- (h) Delegates to AMA to take office January 1, 1983 and serve until December 31, 1984

*Terms Expiring*

David S. Fox, M.D.  
Morris T. Friedell, M.D.  
Henrietta Herbolzheimer, M.D.  
Lawrence L. Hirsch, M.D.  
Joseph R. O'Donnell, M.D.

John J. Ring, M.D.  
George T. Wilkins, Jr., M.D.  
Glen Tomlinson, M.D. (resigned)

- (i) Election of 16th Delegate to AMA to take office immediately and serve until December 31, 1983
- (j) Alternate Delegates to AMA to take office January 1, 1983, and serve until December 31, 1984

*Terms Expiring*

Andrew J. Brislen, M.D.  
Audley F. Connor, Jr., M.D.  
Robert P. Johnson, M.D.  
Boyd McCracken, Sr., M.D.  
Clifton L. Reeder, M.D.  
Richard Rovner, M.D.  
P. John Seward, M.D.

- (k) Election of 16th Alternate Delegate to AMA to take office immediately and serve until December 31, 1983
- (l) Judicial Panel to take office April 18, 1982 and serve until April 1987  
Donald Aaronson, M.D., Chicago, nominated by ISMS President
- (m) Rules and Order of Business to take office April, 1982 and serve until April, 1983  
Five (5) Delegates nominated by the Speaker of the House

9. Fixing of per capita dues for 1983
10. Selection of meeting place and time for next meeting
11. Unfinished business
12. New business
13. Adjournment, (3:30 p.m.) Sine Die

**The IMPAC Council**

**Invites all IMPAC members to attend**

**THE IMPAC ANNUAL MEETING**

**11:45 a.m., Friday, April 16, 1982**

**Immediately following the House of Delegates**

# **Committees of the House of Delegates**

## **1982 Annual Meeting**

### **COMMITTEE ON RULES & ORDER OF BUSINESS**

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (30 days prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

### **COMMITTEE ON CREDENTIALS**

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

### **TELLERS AND SERGEANTS AT ARMS**

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

### **REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS**

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

### **REFERENCE COMMITTEE A**

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to officers, administration, finances and budgets.

### **REFERENCE COMMITTEE B**

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to government health programs, including national health insurance and cost containment.

### **REFERENCE COMMITTEE C**

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to education, manpower and clinical medicine.

### **REFERENCE COMMITTEE D**

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to medical service and economic matters outside government programs.

### **REFERENCE COMMITTEE E**

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to governmental affairs and medical legal matters.

### **REFERENCE COMMITTEE F**

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to public relations, membership and miscellaneous business.



# Program Summary By Days

## ISMS Annual Meeting

**April 16-18, 1982**

**Palmer House, Chicago**

### **Thursday, April 15, 1982**

**9:00 a.m.** Board of Trustees Meeting

### **Friday, April 16, 1982**

**7:30 a.m.** Board of Trustees Meeting

**7:30 a.m.** Rules and Order of Business Meeting

**8:00 a.m.** Registration

**8:00 a.m.** CMS Caucus

**8:30 a.m.** Meeting of Reference Committee Members

**8:30 a.m.** Credentials Committee

**9:30 a.m.** House of Delegates

**11:15 a.m.** IMPAC Annual Meeting

**11:30 a.m.** District Meetings

**11:30 a.m.-1:30 p.m.** Delegates' Brunch

**1:30 p.m.** Reference Committees

**7:30 p.m.** President's Night

### **Saturday, April 17, 1982**

**7:30 a.m.** Public Affairs Breakfast

**8:00 a.m.** Registration

**8:30 a.m.** CMS Caucus

**9:00 a.m.** Credentials Committee

**9:30 a.m.** House of Delegates

**11:00 a.m.** Medical Student Section

**11:30 a.m.** Fifty Year Club

**1:00 p.m.** ISMIS Membership Meeting

**1:00 p.m.** CMS Caucus (if necessary)

**1:30 p.m.** ISMIS Board Meeting

**1:30 p.m.** Credentials Committee

**2:00 p.m.** House of Delegates

**4:45 p.m.** District 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, Caucus

### **Sunday, April 18, 1982**

**7:30 a.m.** Board of Trustees Meeting

**8:00 a.m.** Registration

**8:30 a.m.** Credentials Committee

**9:00 a.m.** House of Delegates

Board of Trustees Reorganization Meeting immediately following House adjournment

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference Issue (November). Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

NAME: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: (    ) \_\_\_\_\_

COUNTY MEDICAL SOCIETY: \_\_\_\_\_

MEDICAL SPECIALTY AND TYPE OF PRACTICE: \_\_\_\_\_

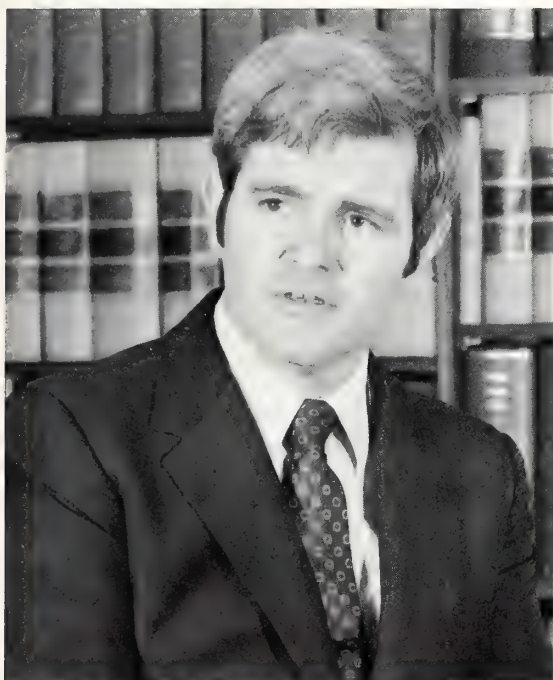
COMMITTEE IN WHICH INTERESTED: \_\_\_\_\_

EXPERTISE FOR THIS COMMITTEE: \_\_\_\_\_

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society  
55 E. Monroe, Suite 3510, Chicago, IL 60603

## YOU'RE INVITED

*To a complimentary Public Affairs Breakfast  
on Saturday, April 17, 1982, 7:30 a.m., Grand  
Ballroom, Palmer House Hotel, Chicago*



*Guest Speaker*

The Hon.

NEWTON L. GINGRICH

United States Congressman

Sixth District — Georgia

*Tickets for the breakfast will be available at convention registration during the ISMS Annual Meeting on a first come, first served basis.*

*For further information, please contact James Tierney at ISMS offices, 55 East Monroe, Suite 3510, Chicago 60603. Telephone (312) 782-1654.*



# Report to the House of Delegates

## Illinois Delegation To the American Medical Association

The Illinois Delegation to the American Medical Association introduced two resolutions at the 1981 interim session of the AMA House of Delegates, December 6-9 in Las Vegas.

*Resolution 63—Adequate Health Insurance Coverage*—was not adopted. This resolution opposed any medical insurance plans which result in less than adequate coverage for subscribers. The reference committee considering the resolution stated that existing AMA policy supports minimum standards of adequate benefits in all health insurance policies sold in the United States with appropriate deductible and co-insurance. The committee noted that the term “total well-being” is difficult to define with respect to the provision of health insurance coverage and that the Board of Trustees is currently investigating reimbursement and coverage of psychiatric services by third parties with a report scheduled for the 1982 annual meeting.

*Resolution 64—Emergency Medical Centers*—was referred to the Board of Trustees (along with Resolution 27—*Freestanding Emergency Care Centers* introduced by Indiana). The reference committee considering these resolutions stated that it had met in executive session with Harris Graves, M.D., chairman of the Task Force on Free Standing Emergency Centers of the Commission on Emergency Medical Services. Dr. Graves described the current efforts of the Task Force to define a true free standing emergency center from a freestanding center which may be equivalent to a physician's office operating without appointments. Some of the criteria now being considered for designating a facility as a free standing emergency center are: (a) providing 24 hour service; (b) should be a component of the regional EMS System; (c) capable of receiving

and treating ambulance transported patients and (d) physicians and staff trained in emergency services regardless of ability to pay.

In view of this current study, the reference committee felt it appropriate to defer action on this matter until the Task Force had an opportunity to submit its report to the Commission on Emergency Medical Services and the Board of Trustees for action and consideration by the House of Delegates at the 1982 annual meeting.

The Illinois delegation met every day during the AMA meeting—Saturday through Wednesday—to discuss the business of the House of Delegates. Dr. Grevas served as chairman of the Reference Committee on Amendments to the Constitution and Bylaws; Dr. Friedell served on the Committee on Rules and Order of Business, and Dr. Reeder was a teller in the House.

All members of the delegation were present, excepting Dr. Clementi, who was unable to attend. Dr. Glen Tomlinson, who resigned from the delegation recently because he has moved to California, was also present.

As usual, Illinois had the largest contingent of students and residents in attendance—12 residents and 12 students. Dr. David Olive, an Illinois resident, was named president-elect of the AMA/RPS, a new position. Ron Davis, University of Chicago student, is AMA/MSS delegate to the House of Delegates.

Members of the Illinois delegation are unanimous in their support of Dr. Frank J. Jirka, Jr., who is a candidate for president-elect of the AMA. Under the direction of Dr. John J. Ring and Dr. Clifton Reeder, the delegation has been organized to make contact with all voting members of the House to urge them to vote for Dr. Jirka in June.

Theodore Grevas, M.D.

*Chairman*

Howard C. Burkhead, M.D.

*Secretary*

# ISMS DELEGATION TO THE AMA

*Delegation Chairman: Theodore Grevas; Secretary: Howard C. Burkhead*

## Delegates

*To serve from Jan. 1, 1981 to Dec. 31, 1982  
(Elected April 15, 1980)*

David S. Fox, Chicago  
Morris T. Friedell, Chicago  
Henrietta Herbolsheimer, Chicago  
Lawrence L. Hirsch, Chicago  
Joseph R. O'Donnell, Glen Ellyn  
John J. Ring, Mundelein  
George T. Wilkins, Jr., Granite City  
One Vacancy

*To serve from January 1, 1982 to December 31, 1983  
(Elected April 7, 1981)*

Herschel Browns, Chicago  
Howard C. Burkhead, Evanston  
Jack L. Gibbs, Canton  
Theodore Grevas, Rock Island  
Morgan M. Meyer, Lombard  
Maynard I. Shapiro, Chicago  
Joseph Skom, Chicago

## Honorary Delegates

Walter C. Bornemeier, Saratoga, Cal.  
Frank J. Jirka, Jr., Barrington Hills  
Burtis E. Montgomery, Long Island, NY

## Alternate Delegates

*To serve from Jan. 1, 1981 to Dec. 31, 1982  
(Elected April 15, 1980)*

Andrew J. Brislen, Chicago  
Audley F. Connor, Jr., Chicago  
Robert P. Johnson, Springfield  
Boyd McCracken, Sr., Greenville  
Clifton L. Reeder, Wilmette  
Richard Rovner, Chicago  
P. John Seward, Rockford

*To serve from January 1, 1982 to December 31, 1983  
(Elected April 7, 1981)*

Alfred Clementi, Arlington Heights  
Allan Goslin, Streator  
Robert C. Hamilton, Chicago  
Harold Lasky, Chicago  
Arthur Traugott, Urbana  
Ronald Welch, Belleville  
Fred Z. White, Chillicothe  
Cyril C. Wiggishoff, Chicago

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## Schedule of Associated Meetings

**Friday, April 16, 1982** **11:15 a.m.**  
*Illinois Medical Political Action Committee  
Annual Meeting*

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**Friday, April 16, 1982** **7:00 p.m.**  
*President's Night  
Featuring The Franz Benteler Royal Strings*

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**Saturday, April 17, 1982** **7:30 a.m.**  
*ISMS Public Affairs Breakfast*  
The Hon. Newton L. Gingrich  
U.S. Congressman, 6th District—Georgia  
Tickets available at ISMS registration desk

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**Saturday, April 17, 1982** **9:30 a.m.**  
*Illinois State Medical Inter-Insurance Exchange  
Annual Meeting of Members*

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*Medical Student Section*  
**Saturday, April 17, 1982** **11:00-1:00**  
*Seminar: "Medical Malpractice"—A Simulated Malpractice Trial*  
For registration information, please contact your school representative.  
**MSS annual business meeting, election of officers and luncheon: 1:00-2:00**



# ISMS Auxiliary Fifty-Fourth Annual Meeting Palmer House Hotel Convention Program FOCUS ON THE 80's

## Thursday, April 15

<b>12:00 noon</b>	Pin and Gavel Luncheon (Past Presidents Only) Hostess: Pat Failor, ISMSA Immediate Past President	
<b>2-4:00 p.m.</b>	Registration	<i>State Ballroom Foyer—Third Floor</i>
<b>3:30 p.m.</b>	ISMSA Pre-Convention Board of Directors Meeting	<i>PDR 18-Club Floor</i>
<b>6:30 p.m.</b>	Cocktails & Dinner—ISMSA Board of Directors	<i>Luau Room (Lower Level)</i>
<b>8:00 p.m.</b>	ISMSA Hospitality Suite Open to members and guests	

## Friday, April 16

<b>8:00 a.m.</b>	Registration	<i>State Ballroom Foyer—Third Floor</i>
<b>9:00 a.m.</b>	First Delegates Session	<i>State Ballroom</i>
	Call to Order and Greetings Bonnie Keegan, ISMSA President	
	Opening Ceremonies Presentation of Colors Royal Grenadiers of ISMSA Kankakee County National Anthem—Dan Liddell, Soloist Dorothy Kerr, Accompanist	
	Auxiliary Pledge—Pat Failor, Immediate Past President	
	Welcome—Janice Springer, Convention Chairman	
	Introductions—ISMS President AMAA President-Elect Visiting Guests	
	<b>Keynote Speaker—Lorna Straus, Ph.D., associate professor of anatomy, University of Chicago</b>	
	Reading of Convention Rules of Order— Connie Graff, Parliamentarian	
	Adoption of Convention Program— Janice Springer, Convention Chairman	
	Report of Credentials and Registration— Mary Ellen Burnett, Chairman	
	Appointment of Reading and Reference Committee	
	Minutes of 1981 Annual Meeting	
	Presentation of 1982-83 Budget— Jean Hodges, Finance Chairman Betty Payne, AMAA President-Elect	
	President's Report— Bonnie Keegan, President	

<b>12:00 noon</b>	Cocktails—cash bar	<i>Monroe Room—Sixth Floor</i>
<b>12:30 p.m.</b>	President's Luncheon Honored Guests—ISMSA Past Presidents Invocation— Dr. Gerald Downie, Kankakee Introduction of Guests Fashion Show—Marjorie Neale, Proprietor, Designer's Shop, Kankakee Speaker— <b>Diane Holum, Former Olympic Skating Coach</b>	
<b>2:30 p.m.</b>	Second Delegates Session Nominating Committee Report Election of Officers Election of 1982-83 Nominating Committee Presentation of Humanitarian Award— Maggie Hollowell, Chairman Memorial Service— Dan Liddell, Kankakee Dorothy Kerr, Kankakee	<i>State Ballroom</i>
<b>4-5:00 p.m.</b>	Reference Committee "Delegates—Who are They?" "Auxiliary vs. the 80's"	<i>Parlor C—Sixth Floor Parlor D—Sixth Floor</i>
<b>5-6:00 p.m.</b>	"Cults: A Problem Today" "Jazzercise: A Way to Fight Stress"	<i>PDR 6—Third Floor PDR 8—Third Floor</i>
<b>7:00 p.m.</b>	ISMS President's Night Cocktails and Dinner	<i>Red Lacquer Room—Fourth Floor</i>

## Saturday, April 17

<b>7:00 a.m.</b>	Public Affairs Breakfast	<i>Grand Ballroom—Third Floor</i>
<b>8:00 a.m.</b>	Registration	<i>State Ballroom Foyer—Third Floor</i>
<b>8:00 a.m.</b>	Workshop for County Presidents-Elect Diane Hinderliter, ISMSA President-Elect (County Presidents and Legislative Chairmen invited)	<i>PDR 16—Club Floor</i>
<b>9:30 a.m.</b>	Third Delegates Session Frank J. Jirka, Jr., M.D., AMA Trustee Highlights of 1982 AMAA Annual Meeting Election of Delegates—1982 AMAA Annual Meeting Councilors' Reports County Presidents' Reports Awards AMA-ERF Membership Health Projects SASii Displays	<i>State Ballroom</i>
<b>12:30 p.m.</b>	Installation Luncheon <b>Installation of Diane Hinderliter</b> 1982-83 ISMSA President <b>Students of the Suzuki School</b> Mickey Glatter, ISMSA Past President Installation Officer Courtesy Resolution Closing of 1982 Annual Meeting	<i>Grand Ballroom</i>
<b>3:00 p.m.</b>	Post-Convention meeting of 1982-83 ISMSA Board of Directors	<i>PDR 9—Third Floor</i>



# IMPAC

**Illinois State Medical Society  
Political Action Committee**  
55 East Monroe Street  
Chicago, Illinois 60603  
312/782-1963

## NOTIFICATION OF ANNUAL IMPAC MEETING

The 1982 annual meeting of the Illinois State Medical Society Political Action Committee (IMPAC) will be held on Friday, April 16, 1982, immediately following the adjournment of the ISMS House of Delegates:

11:45 a.m. approximately  
Red Laquer Room  
Palmer House Hotel  
Chicago, Illinois

All members of IMPAC are invited and encouraged to attend.

The 1982 IMPAC Nominating Committee has met and nominated the following individuals for membership on the IMPAC Council:

### Terms Expiring 1985

Robert C. Hamilton, M.D.	Chicago
Frank J. Jirka, M.D.	Barrington
James Laidlaw, M.D.	Champaign
Harold J. Lasky, M.D.	Chicago
Tassos Nassos, M.D.	Chicago
Edward Ragsdale, M.D.	Alton
Clifton L. Reeder, M.D.	Chicago
Willard C. Scrivner, M.D.	Belleville
Earl Suckow, M.D.	Mt. Prospect
Cyril C. Wiggishoff, M.D.	Chicago

George T. Mitchell, M.D.  
Chairman - Nominating Committee  
IMPAC

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, & 110.5. (Federal Regulations require this notice.) IMPAC reports are filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois, 62704. Voluntary membership contributions support political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC.

# Resolutions

## 1982 Annual Meeting

### ISMS House of Delegates

The following resolutions were received at ISMS headquarters by February 12 and, according to provisions of the bylaws, are printed in *IMJ* by title and subject. Final deadline for resolutions was March 17. At this writing, it is anticipated that other resolutions will have been submitted for consideration before that deadline. These will be included in the Delegates' packet of materials.

<i>Number</i>	<i>Introduced by</i>	<i>Subject</i>
1 (A-82)	Edwin Sinaiko, M.D.	Liability Insurance Costs
2 (A-82)	William B. Frymark, M.D., for the DuPage County Medical Society	Tobacco Farm Subsidies
3 (A-82)	Lawrence L. Hirsch, M.D., for the Board of Trustees	Amendments to Chapter II, Sections 3 & 4 of the Bylaws (removing "funds")
4 (A-82)	Lawrence L. Hirsch, M.D., for the Board of Trustees	Amendments to Chapter VII, Section 12, of the Bylaws (naming "ISMS Benevolent Fund, Inc.")
5 (A-82)	Lawrence L. Hirsch, M.D., for the Board of Trustees	Amendments to Chapter IX, Sections 2,3,5,6,7, & 8 of the Bylaws (removing "Liaison with AMSA," relocating description of Council on Affiliate Societies, and removing names of specific government agencies)
6 (A-82)	Lawrence L. Hirsch, M.D., for the Board of Trustees	Amendment to Chapter X, Section 4 of the Bylaws (to require members to comply with constitution and bylaws of constituent society)
7 (A-82)	Lawrence L. Hirsch, M.D., for the Board of Trustees	Amendments to Chapter XI, Part 3 of the Bylaws (changing "Principles" of medical ethics to "Code")
8 (A-82)	Morris T. Friedell, M.D., for the Board of Trustees	Removal of Mandatory CME Requirements as Conditions for Medical License Renewal
9 (A-82)	Robert C. Hamilton, M.D., Chairman, Cook County Delegation	Insurance Assignments
10 (A-82)	Eugene P. Johnson, M.D., Treasurer, for the Board of Trustees	Dues Increase
11 (A-82)	Clifton L. Reeder, M.D., Speaker	Procedure for Legal Counsel Review of House Actions
12 (A-82)	Joseph Perez, M.D., for the Board of Trustees	Modification of Dues Statement
13 (A-82)	Fred Z. White, M.D., President, for the Board of Trustees	Monitoring UR Activities
14 (A-82)	Morris T. Friedell, M.D., for the Board of Trustees	Candidacy of Frank Jirka, Jr., M.D., for AMA President-Elect



# CONVENTION '82

The 142nd Annual Meeting  
*of the*  
Illinois State Medical Society  
*will be held at the*  
Palmer House  
State and Monroe Streets  
Chicago, Illinois  
April 16-18, 1982

- ISMS House of Delegates
- Gala President's Party
- Annual IMPAC Meeting
- Public Affairs Breakfast

Further information about convention may be obtained by contacting the Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603. Phone: (312) 782-1654.

## PLAN NOW TO ATTEND . . . CONVENTION '82

PALMER HOUSE HOTEL  
State and Monroe Streets  
Chicago, IL 60603

ISMS/ISMSA ANNUAL MEETING  
April 16-18, 1982  
Palmer House, Chicago

Name (please print) \_\_\_\_\_

Company Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Arrival \_\_\_\_\_ Hour \_\_\_\_\_ am/pm Departure Date \_\_\_\_\_

### PLEASE CHECK RATE DESIRED

Singles: ☐ \$60  
Doubles: ☐ \$75  
Twins: ☐ \$75

Parlor & 1 Bedroom Suites: ☐ \$130 & up  
Parlor & 2 Bedroom Suites: ☐ \$330 & up

### PALMER HOUSE TOWERS

Singles: ☐ \$ 80 ☐ \$ 90 ☐ \$100 ☐ \$110  
Doubles: ☐ \$100 ☐ \$110 ☐ \$120 ☐ \$130  
Twins: ☐ \$100 ☐ \$110 ☐ \$120 ☐ \$130

Parlor & 1 Bedroom Suites: ☐ \$150 & up  
Parlor & 2 Bedroom Suites: ☐ \$350 & up

For better choice of accommodations, early reservations are suggested. If rate requested is not available, the next available rate will be confirmed.

Rooms will be held until 6:00 p.m. on stated date of arrival, unless a later time is confirmed.

All room rates are subject to additional charges equivalent to state, county and city taxes.

## Viewbox

(Continued from page 163)

### DIAGNOSIS: PULMONARY ASPERGILLOSIS

Figures 1 and 2 are PA and lateral chest roentgenograms of a patient with an aspergilloma (fungus ball) arising in a previously formed tuberculous cavity. Figures 3 and 4 are PA chest roentgenogram and a lateral tomogram of a mucoid impaction in an asthmatic with allergic bronchopulmonary (hypersensitivity) aspergillosis. Figure 5 is a PA chest roentgenogram of an immune suppressed patient suffering from invasive pulmonary aspergillosis.

Aspergillosis is a mycotic disease usually caused by the organism *Aspergillus fumigatus* although many other species of this dimorphic fungus may cause human disease. *Aspergillus* is commonly found in nature and is of low pathogenicity. It is frequently cultured from the upper respiratory tract of persons with no clinical disease or found as a contaminant in the laboratory. When the cause of clinical disease, the portal of entry is most commonly the respiratory tract and usually occurs in the compromised host, although very rarely primary invasive infection in the otherwise healthy person may occur. Three disease entities due to *Aspergillus* are well-known: pulmonary mycetoma (aspergilloma), allergic bronchopulmonary aspergillosis, and invasive pulmonary aspergillosis. More recently, attention has been called to a chronic necrotizing or "semi-invasive" disease state due to *Aspergillus* suggesting that disease due to *Aspergillus* is a continuum which is dependent upon the host's underlying immune status and lung architecture.<sup>1</sup>

#### Pulmonary mycetoma

A mycetoma or "fungus ball" is a tangled mass of mycelia, mucous, and cellular debris in a pulmonary cavity. The pulmonary cavity is almost always caused by an underlying disease state such as tuberculosis, sarcoidosis, bronchial cyst, or neoplasm. There is no invasion of the cavity wall by *Aspergillus* which merely resides in the cavity as a saprophyte. Clinically patients with pulmonary mycetoma may have hemoptysis but are otherwise healthy unless debilitated by an underlying disease. Their hemoptysis may occasionally be severe, however, and fatal hemorrhage has occurred so that resection of the involved lung may be required.<sup>2</sup>



FIGURE 6.

This is a roentgenogram of the same patient in Figures 1 and 2. The patient is in a Trendelenburg position and the fungus ball has moved superiorly within the cavity so that there is a crescent shaped air space at its base.

Radiographically the mycetoma is a rounded soft tissue density mass within a rounded cavity. The cavity is usually thin walled and contiguous with a pleural surface. The mass is freely moveable within the cavity and a crescent-shaped air space between the fungus ball and the cavity will change position as the patient is moved (Fig. 6). The mass may calcify and may sometimes change in size but often remains constant in appearance for years. In some instances *Aspergillus* superinfection of a pre-existing cavity may be manifest





**FIGURE 7.**

There was a long standing cavity of the apex of the left lung. The patient developed a band of thickening adjacent to the lower margin of the cavity which is superimposed on the left clavicle here. At surgery a mycetoma was found in the LUL cavity. This type of thickening next to the wall of a cavity sometimes precedes fungus ball formation.

only by pleural thickening preceding the formation of a visible fungus ball by months or even years (Fig. 7).<sup>3</sup>

### **Allergic Bronchopulmonary Aspergillosis (Hypersensitivity Aspergillosis)**

This disease entity is characterized by bronchial asthma, recurrent pulmonary densities on the chest roentgenograms due to mucous plugs containing aspergilli, eosinophilia, and immunologic evidence of allergy to the antigens of *Aspergillus*.<sup>4</sup>

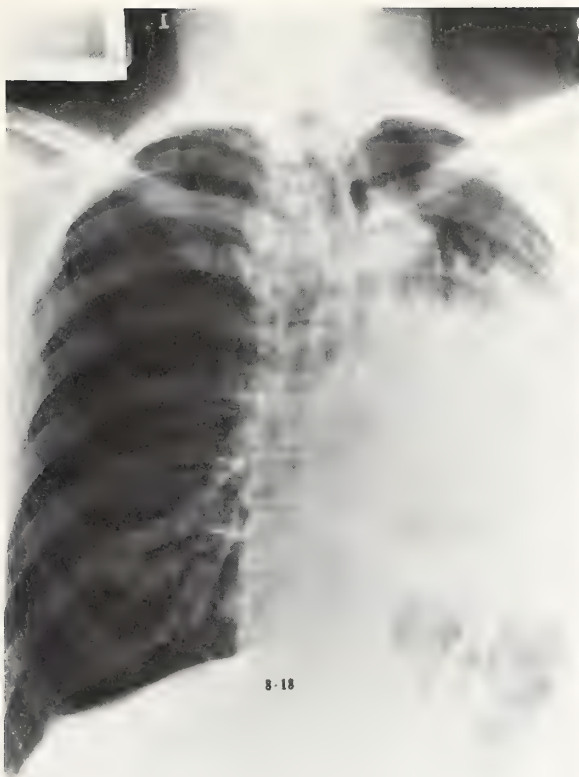
Acting as more than a saprophyte, the fungus elicits a hypersensitivity reaction including Type I and Type III. The immediate Type I reaction, thought to be mediated by IgE, is evidenced by decreased forced expiratory volume resulting from inhalation of *Aspergillus* extract. The Type III reaction may be the cause of the eosinophilic and mononuclear cellular infiltration that has been associated with bronchial wall destruction in the disease. Late changes after resolution of the mucous plugs are central bronchiectasis and fibrosis. Rarely is a pulmonary mycetoma associated.

Clinically the patients have typical asthma, in fact, bronchial asthma is usually long-standing in patients initially diagnosed as having allergic bronchopulmonary aspergillosis. Later in the course of the disease symptoms of bronchiectasis may occur including hemoptysis, purulent expectoration, and expectoration of mucous plugs. Peripheral blood and sputum eosinophilia are major criteria for the disease. Positive skin test reactivity to *Aspergillus fumigatus* is also characteristic. Other findings include elevated serum IgE levels and serum precipitating to *Aspergillus* extracts.

Radiographically non-specific transient air space consolidation commonly occurs which may be massive in some cases (Fig. 8).<sup>5</sup> A more specific finding is that of mucoid impaction. Central soft tissue densities with finger like projections corresponding to the branching of the mucous filled bronchial tree are present, most commonly in the upper lobes (Fig. 9). Distally atelectasis may occur (Fig. 8) but usually this is not observed.<sup>6</sup> The densities may be transient or persist for weeks. After bronchiectasis has developed bronchography may be helpful to demonstrate the saccular central bronchiectasis typical of allergic bronchopulmonary aspergillosis, which is in the contrast to the distal bronchiectasis seen in most other diseases. With long standing disease there occurs some degree of chronic contraction of the upper lobes with linear opacities.<sup>7</sup>

### **Invasive Pulmonary Aspergillosis**

Invasive pulmonary aspergillosis is a necrotizing pneumonia almost always found in immune compromised persons although it may rarely affect the otherwise totally healthy individual exposed to an overwhelming inoculum of organisms. After tracheobronchial aspiration, endobronchial proliferation of *Aspergillus* occurs followed by transbronchial invasion characteristically involving the pulmonary arterioles with thrombosis and leading to ischemic necrosis. Two basic types of macroscopic lesions have been de-



**FIGURE 8.**

There is an air space consolidation and atelectasis of the lingula and left lower lobe in this patient with allergic bronchopulmonary aspergillosis. The air space consolidation arose over a matter of days and cleared in two weeks. *Aspergillus* in mucous plugs were recovered at bronchoscopy.



**FIGURE 9.**

There are multiple branching soft tissue density lesions near the hila (arrows). These densities are caused by multiple bronchocoeles in this patient with asthma and allergic bronchopulmonary aspergillosis.

scribed:<sup>8</sup> "target lesions" and hemorrhagic infarctions. Target lesions are round nodular lesions varying in size from microscopic to 3cm in diameter with gray-yellow necrotic centers surrounded by a rim of hemorrhage. They may be single or multiple and have a propensity to cavitate (Fig. 5). Hemorrhagic infarctions are wedge-shaped, pleural based lesions caused by thrombosis of a pulmonary artery due to fungal invasion from the surrounding parenchyma. Organs other than the lung are involved in a minority of cases of invasive aspergillosis but when disseminated the systems most commonly affected are the gastrointestinal tract, paranasal sinuses, brain, and

liver.

Clinically, the findings of invasive pulmonary aspergillosis are non-specific, usually consisting of fever and bronchi with no response to antibiotics. The patients may have extensive pulmonary disease with minimal symptoms. The patients are almost always compromised and most have hematologic malignancies and are receiving chemotherapy or are organ transplant recipients receiving immunosuppressive therapy. Symptoms of invasive pulmonary aspergillosis may be masked by the patient's underlying illness or by other superinfections immune compromised patients are predisposed to.



Laboratory testing is often not helpful and the definitive diagnosis usually requires biopsy.<sup>9</sup> Diagnosis usually comes late and some strains of *Aspergillus* have little sensitivity to amphotericin B rendering the prognosis grave.

Invasive pulmonary aspergillosis almost always results in parenchymal lung changes that are perceptible roentgenographically unlike the lesions of pulmonary candidiasis in immune compromised patients which are usually roentgenographically invisible.<sup>8</sup> Initially the roentgenograms demonstrate 1-3cm diameter nodular or patchy water density lesions which correlates with the target lesions described pathologically. These lesions may be single or multiple, but rarely they appear as a disseminated miliary pattern. They often cavitate or progress to larger areas of air space consolidation. When larger arteries are invaded and thrombosed wedge-shaped, pleural-based areas of infarction may be seen. The late stage of the disease is commonly manifest by large bilateral areas of air space consolidation.

### Chronic Necrotizing ("Semi-Invasive") Pulmonary Aspergillosis

The entities of pulmonary aspergillosis, allergic bronchopulmonary aspergillosis, and invasive pulmonary aspergillosis are well established. Chronic lung disease due to *Aspergillus* in mildly immune compromised patients has also been described.<sup>1,10</sup> Persons with prior malignancy, chemotherapy, irradiation, alcoholism, and sarcoidosis have been noted to have slowly progressive pulmonary air space consolidation and progressive parenchymal destruction which was attributable to *Aspergillus* by tissue specimen. Cavitory lesions containing a fungus ball developing over a period of months have been described which have a similar appearance to the classic aspergilloma but which have a gradual increase in cavity size and occur in lung in which there is no underlying cavity. Pathologically there is tissue necrosis and branching septate hyphae surrounded by chronic inflammatory cells and fibrous reaction but no true fungal invasion microscopically.<sup>1</sup> Roentgenographically there is a patchy infiltrate early in the disease process which may then cavitate with progressive parenchymal destruction and pleural reaction. This chronic necrotizing disease state in which *Aspergillus* apparently creates its own cavitory lesion but then acts non-invasively suggests that there is a continuum of behavior from the simple saprophyte of the mycetoma to the invasive destructive pathogen of invasive pulmonary aspergillosis. The manifestations of the

*Aspergillus* infection depend on the individual's underlying lung architecture, immune state, and hypersensitivity status.

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## THE PROBLEM

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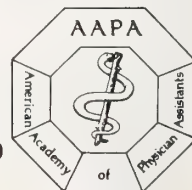
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# Abstracts of Board Actions

(Continued from page 160)

## OPEN DRUG FORMULARY

Because of the financial situation of the state, the Board agreed not to support proposed legislation mandating an open formulary for IDPA recipients.

Currently, Illinois maintains a restrictive drug formulary system except when: (A) A life threatening situation exists; or (B) A physician certifies that, in his/her judgment, the use of a specific drug means the difference between hospitalization or out-patient treatment.

Several drug companies had requested ISMS' support for the proposed open IDPA drug formulary, which would include all drugs.

## IDPA DRUG MANUAL

The Board will urge the Illinois Department of Public Aid to *include* the following drugs in the IDPA Drug Manual: Nizoral, Transderm-Nitro, Tridesilon, Carafate, Nasalide, Restoril, Misdamor, Moduretic, Blocadren, Lacrisert (prior approval only), and Tenormin (prior approval only).

The Board will urge IDPA to *remove* the following drugs from the Drug Manual: Cordran, Valison, Decadron Phos Respighaler, Anhydron, Benzthiazide, Chlorothiazide Sod. Inj., Dichlorphenamide, Hydroflumethiazide, Hydromox Methyclothiazide, Naturetin, Neptazone, Renese, Saluron, Chlorothiazide 500 MG, Edocrin-Sodium Inj., Ethoxzolamide, Mersalyc/Theophyllin Inj., Thiomerin Inj., Amobarbital Sod. Caps., Alurate Elixir Red, Amobarbital Sod. Inj., Ethchlorvynol, Largon Inj., Lotusate TAB, Seconbarbital Elix., Glutethimide Methaqualone Nodular, Secobarbital Inj., and Valmid CAP.

## INCREASE CME ACCREDITATION FEES

The following increases in CME accreditation fees were authorized effective March 1, 1982:

- *Registration fee*—Increased from \$100 to \$200. This is a one-time fee payable upon submission of Form Ac-5, "Preliminary Questionnaire." (Exception: Component societies of ISMS are exempt from this fee.) Institutions that fail to observe the 12-month rule, however, must pay the registration fee again.
- *Survey fees of hospitals or other medical organizations of 49 or fewer members*—increased from \$500 to \$750.
- *Survey fees of all other applicants*—Increased from \$750 to \$1,000.

In addition, the Board authorized a new category of accreditation applicant—component medical societies of ISMS. Fees for these applicants will be \$2 per member with a minimum fee of \$250 and a maximum of \$500.

## SPECIAL PROGRAMS

Acting on requests for special programs, the Board voted to:

- Approve ISMS sponsorship of an alcoholism education program to be held just before the Society's 1982 Annual Meeting in April. The program, which will focus on alcohol abuse among young persons, will be funded by a grant from the Division of Alcoholism, Illinois Department of Mental Health and Developmental Disabilities.



- Approve ISMS co-sponsorship of the Biennial Nutrition Symposium to be held March 31 at the Ramada Inn O'Hare, Chicago. The program—which offers five hours of CME credit, Category 2—will be co-sponsored by the Chicago Nutrition Association and the Chicago Chapter of the Institute of Food Technologists.
- Approve ISMS co-sponsorship of a 1983 nutrition program designed specifically to meet physician education needs. The program—to be co-sponsored by the Illinois State Council on Nutrition,—would not be a duplication of the material presented in the Biennial Nutrition Symposium.
- Authorize the ISMS Council on Medical Services to develop a proposal for a series of programs on adolescent health problems to be conducted in late 1982 or 1983.
- Endorse the Illinois Continuity of Care Organization's 6th Annual Meeting-Workshop to be held May 12-13, at the Ramada Inn Convention Center, Champaign. The program is titled "Continuity of Care—A Voice to be Heard."

## APPOINTMENTS/NOMINATIONS

The Board appointed:

- *Dr. Lee Gladstone*, Chicago, chairman of the ISMS Panel for the Impaired Physician;
- *Dr. Peter Talso*, Evergreen Park, ISMS representative to the IDMHDD Citizens Advisory Council on Alcoholism; and
- *Dr. Pedro Poma*, Chicago, to fill a vacancy on the ISMS Peer Review Appeals Committee.

It will also nominate Dr. Lawrence L. Hirsch, Chicago, for appointment to the Illinois Medical Examining Committee to fill a vacancy left by the recent resignation of Dr. Richard Rovner.

## PROPOSED RESOLUTIONS

The Board will introduce two resolutions at the 1982 Annual Meeting seeking House of Delegates authorization to:

- Monitor utilization review activities, provide for the dissemination of appropriate information about these activities between ISMS and local physician review entities; and
- Amend the 1983 dues bill to allow ISMS members to designate a voluntary contribution to AMPAC. If approved, the new dues bill would provide members with the opportunity to contribute to IMPAC, AMPAC or both.

The Board also will request the House to: (a) Endorse and support the candidacy of Dr. Frank J. Jirka, Jr., for president-elect of the AMA; and (b) Amend the Bylaws to allow the Board to defer action on a resolution adopted by the House when advised by legal counsel.

## OTHER ACTIONS

In other actions, the Board of Trustees:

- Adopted a statement on the Joint Council on Accreditation of Hospitals' proposed changes in its standards for psychiatric services in hospitals. The statement will be mailed to JCAH in response to its request for comments.
- Directed the Ad Hoc Committee on Utilization Review and ISMS staff to carefully monitor "cost containment" activities, seeking—when appropriate—to participate in order to provide medical input and to preserve a high standard of quality patient care.
- Authorized development of a brochure on the importance of infant car seats which will be disseminated to physicians for distribution to their patients.

- Authorized continued discussions with other interested, appropriate groups in exploring the issue of health coalitions.
- Referred back for further study the matter of the state's official triplicate prescription system, and directed that information regarding the system's application and efficacy be requested from the Illinois Dangerous Drugs Commission.

## **POLICY REVISIONS**

As a result of House of Delegates' actions taken at the 1981 Interim Meeting, the Board approved publication of the following policies and policy revisions in the 1982 Policy Manual.

## **NEW AND REVISED ISMS POLICIES**

*The following policies were adopted or revised by the House of Delegates at its 1981 Interim Meeting. They were approved for publication in the 1982 Policy Manual by the Board of Trustees at its January 23, 1982 meeting.*

### **HEALTH PLANNING (Resolution 4)**

ISMS urges physician participation in the health planning process at all levels, with strong emphasis on planning at the local community level. ISMS supports health planning at the local level, and opposes centralized health planning.

ISMS recognizes the distinction between health planning functions and health regulatory functions in accordance with the definition of health planning in the AMA Statement on Voluntary Health Planning, which states that "health planning is defined as a structured process of determining appropriate community health and medical needs and priorities and assisting in the development or allocation of resources to meet those needs within a given locale or region." It does not include reference to sanctions or regulatory authority.

### **PUBLIC AID (Resolution 9)**

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by state/federal programs to physicians should be based upon the usual and customary fee concept.

Because modern medical care frequently requires multispecialty medical management, including primary care physicians and specialists working together for the benefit of the patient, traditional fees for multispecialty care for Public Aid patients should be made available without extensive justification procedures.

### **DRUNK DRIVERS (Resolution 7)**

ISMS supports laws providing for stiffer sentencing of drunk drivers and encourages the judiciary to recommend rehabilitative treatment as an additional means of dealing with people convicted of driving while under the influence of alcohol.

### **CHILD ABUSE (Resolution 11)**

ISMS urges all state health agencies and family service agencies which become involved in child abuse cases, to conduct, promptly, necessary investigation of the family environment prior to the release of the child for return to the same home where the abuse occurred.



## **CHILD SAFETY RESTRAINTS (Resolutions 18 and 19)**

ISMS supports and encourages public education and legislation promoting child safety restraint use (infant and toddler car seats) and encourages physicians and others to discuss their benefits with all parents. Physicians are encouraged to learn about important safety features which have proven effective.

## **PEER REVIEW (Resolutions 20, 30 and 37)**

Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues.

Peer review shall be conducted by a local medical society, or its designee, at the local level whenever possible. Major ethical relations questions identified during deliberation of the Peer Review Committee shall be appropriately referred.

ISMS supports physician assessment of the quality of medical care and urges physicians to maintain control and direction over peer review, regardless of what mechanisms evolve for peer review, and over public or private funds that are directed to such activities.

## **UTILIZATION REVIEW**

ISMS encourages hospital medical staffs to perform focused utilization review of all patients in selected diagnostic categories, regardless of the source of payment, and urges all third party payors—private carriers as well as government—to provide reimbursement to hospitals and physicians for time and expense incurred in focused utilization review.

ISMS further urges the Illinois Department of Public Aid to continue to use existing physician peer review organizations, and will vigorously oppose the use by IDPA of any alternative peer review structure.

## **HEALTH INSURANCE, VOLUNTARY PLANS (Resolution 31)**

ISMS endorses the principle of voluntary health insurance that provides adequate health coverage. Fixed fee schedules should be recognized as indemnification, etc. (See Policy Manual for remainder of statement).

## **CODE OF ETHICS (Resolution 26)**

The following Code of Ethics represents standards of conduct defining the essentials of honorable behavior for the physician. They are not laws.

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

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BY MARI LAKADAT/McLEAN COUNTY CHAPTER

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Carefully read resumes often tell the tale  
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Did this assistant, in the years of employment,  
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1. Promoting Health/Preventing Disease: Objectives for the Nation. U.S. Department of Health and Human Services, November 1980  
\*An in vitro simulation of gastric ulcer acid level conditions based on standard laboratory methodology. Data on file. Ayerst Laboratories  
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## EKG

(Continued from page 155)

Answers: 1. B, D, E. 2. E

The twelve lead ECG shows sinus rhythm with a normal PR interval of 0.16 seconds and a normal QRS duration of 0.08 seconds. There is no delta wave of the Wolff-Parkinson-White syndrome and no voltage criteria for left ventricular hypertrophy. There are deep Q waves in leads II, III and AVF compatible with an inferior myocardial infarction. The Q wave in lead V<sub>6</sub> is also significant suggesting a lateral infarction or extension. There is a tall R in lead V<sub>1</sub> that is more than 0.04 seconds with an upright T wave. This suggests a posterior or dorsal wall infarction. All of these myocardial infarctions are compatible with significant disease in a large dominant right coronary artery. The left ventricular angiogram demonstrates the infarction as inferior base and apex contraction abnormalities. Although the area of myocardium damaged was relatively large, the patient did not go into congestive heart failure. However, he developed an unstable or accelerated pattern of angina pectoris shortly after the myocardial infarction. This justified a coronary angiogram. The angiogram showed significant disease in the coronary arteries supplying his good myocardium as well as the area of previous infarction. Angina following a myocardial infarction has a serious prognosis. This is especially true if ischemia is occurring in an area of myocardium at a distance from the old myocardial infarction. This justifies an aggressive therapeutic approach. Our patient had aortacoronary bypass surgery.

For further reading on this common problem see Schuster and Bulkley in *The New England Journal of Medicine* 305:1101, November 5, 1981. ◀



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**CONTRAINDICATIONS** — Known hypersensitivity to the drug. Acute narrow angle glaucoma.

**WARNINGS** — Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

**Pregnancy and Lactation:** Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

**PRECAUTIONS** — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

**ADVERSE REACTIONS** — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

**INTERACTIONS** — Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

**OVERDOSAGE** — Take general measures as for any CNS depressant.

**SUPPLIED** — TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets, TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

**REFERENCES** — 1. Hollister LE: *Anxiety: The Therapeutic Dilemma*, No. 2, Management Alternatives, Monograph 97-0544, 1981, p 14. 2. Snyder SH: *Anxiety: The Therapeutic Dilemma*, No. 2, Management Alternatives, Monograph 97-0544, 1981, p 7.

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# Illinois Housestaff News

## The Eye of a Storm

A mobile glaucoma screening unit is jointly sponsored by the University of Illinois Eye and Ear Infirmary and the Lions of Illinois Foundation. The Foundation, the charitable arm of the Illinois Lions Clubs, is dedicated to aiding the blind and visually handicapped and the hearing impaired. They are also involved in sight conservation and restoration and eye research. The mobile glaucoma unit, which performs more than 30,000 screenings annually, travels to over 600 Illinois communities to detect this potentially blinding eye disease. Referrals are made to local ophthalmologists when medically necessary, and literature is distributed to educate the public.

In early January, I was scheduled to perform the eye screenings during the mobile unit's visit to central western Illinois. En route at night from Chicago, the driver and I encountered a continuous rain that rapidly evolved into a snow and ice blizzard. Channel 19 on the unit's citizen band radio crackled with the amazement, concern, and frustration of surprised travelers.

My thoughts started drifting along with the falling snow. Gazing out, my window became a direct view into the eye through an imaginary cornea constantly cleared and lubricated with the rhythmic blink of windshield wipers. Periodically, between the wiper blades and snow-dusted glass, ice synechiae developed, requiring lysis, as lambchop-sized ice formations precipitated elsewhere—a reflection of the storm's chronicity. Headlights with glaring high beams only exaggerated the Tyndall phenomenon of the 4+ intense storm, as I hazily discerned snowball opacities, sheathed telephone cables, peripheral snowband formations, and swirling drifts in this cavity of night. Salt trucks added an inconsequential topical treatment as they attempted to plow the accumulating debris.

Daylight brought a more dilated view of the surroundings. The inflammatory weather had quiesced, and the surrounding background be-

came more distinct—silhouetted haystacks appeared as granulomatous masses; black-topped arteries glistened with iced sheathing; barren trees remained as vestiges of obliterative vascular processes; patches of barren soil resembled pigment formations and cross-winds continued to swirl the drifting snow into fine opacities. By the second day, direct and indirect beams of sunshine illuminated a melting storm. Visual acuity returned to normal and arterial congestion cleared, aided by the topical addition of balanced salts. Precipitates slowly dissolved, leaving scattered sheathings, mounds, pigmented branches, and barren areas as evidence of a fulminant episode.

The storm's chronicity, development of mutton-fat precipitates, and presence of granulomatous deposits in the face of intense media haze distinguished this process as granulomatous uveitis. In the establishment of a differential diagnosis, possibilities considered were tuberculosis, syphilis, sarcoidosis, toxoplasmosis, Vogt-Koyanaga-Harada syndrome, Behcet's disease, sympathetic ophthalmia, Toxocara cana, and others.<sup>1</sup> Whatever the etiology, we passed through the eye of the storm uneventfully!

Glaucoma screenings during this one week detected 6-8% suspects out of the 175 people screened; *i.e.*, those people with ocular hypertension who may or may not have glaucoma. When advised to go to a physician, approximately 80-90% of the people did not know the distinction between an ophthalmologist and an optometrist, nor did they know the meaning or consequence of glaucoma, unless "their neighbor had it." These findings point out the continuing necessity for physicians to educate the public regarding health. It is equally important for those administering care to know that charitable services, such as the Lions of Illinois Foundation, exist to promote these concepts.

Previously, the mobile glaucoma unit screened for diabetes, in addition to hypertension. This



ended when local health departments criticized the free screenings with urine dextrose sticks as less diagnostic compared with the blood tests they provided. With ensuing budget restraints on state and local governments,<sup>2</sup> mobile units like the glaucoma bus may find an increasing role in providing health care to the public, if screening tests are properly supervised and uniformly administered. The ISMS and housestaff can benefit by informing the public of these services, assisting as screening physicians, and lobbying for the institution of mobile programs. Only in this fashion can the wheels keep moving.

David J. Palmer, M.D.  
Secy/Editor ISMS/RPS

References

1. Peyman, G.A., Sanders, D.R., Goldberg, M.F.: *Principles and Practice of Ophthalmology*, Volume II, W.B. Saunders and Company, Philadelphia, 1980.  
2. Palmer, D.J.: "Thoughts on Health Care Economics," *Illinois Medical Journal*, 160:5, p. 390, November, 1981.

1982 PAIN & STRESS  
MANAGEMENT  
WORKSHOPS

March 6	Vancouver
March 19	Portland, OR
March 26	San Francisco, CA
March 30	Springfield, MO
May 7-9	Seattle, WA
May 13-15	Springfield, MO,
	<small>with 10 experts</small>
June 11	Houston, TX
July 19	Stevens Point, WI
Nov. 6-7	Milwaukee, WI

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John Butler  
Executive Vice-President

# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**BENTON:** Family Physician wanted to join growing medical staff associated with a modern, 113-bed community hospital in southern Illinois. Guarantee and other benefits. Excellent recreational and university facilities nearby. **CONTACT:** Ann Acton, Franklin Hospital, Benton, 62812, (618) 439-3161, Ext. 367/368. (4)

**CARBONDALE:** Family or General Practice. Community Health Center in southern Illinois, 10 miles from SIU-Carbondale. Affiliation with Black Lung Clinic Programs possible. Established practice with multi-disciplinary staff. Position available immediately. Salary, fringe benefits are very competitive; malpractice insurance and vacation also provided. **CONTACT:** George M. O'Neill, Shawnee Health Service & Development Corporation, 103 S. Washington, #210, Carbondale 62901 (618-457-3351). (4)

**CENTRAL ILLINOIS:** Two community hospitals within twenty minutes of each other are currently seeking a urologist. Possible partnership with consulting urologist now servicing this area. More patients than one urologist can handle. Area is known for recreational activities. **Contact:** Search Committee, P.O. Box 430, Pana, 62557. (217-562-2131 x271) (4)

**CLIFTON:** Service Area, 8,500—Immediate opening for family practitioner in rural setting. First year: guarantee, office space/staffing provided. Seventy miles south of Chicago on interstate highway. Excellent school system. Obstetrics or general internal medicine background helpful. **CONTACT:** George Rasmussen, Central Community Hospital, Clifton 60927. AC 815-694-2392. (10)

**CLINTON, IA:** Internist (with/without subspecialty), Surgeon, OB-GYN, and ENT physicians are needed in Clinton. Multi-specialty group serving large part of Western Illinois. Excellent opportunity for quality care, professional interaction with friendly colleagues and financial security. **Contact** Dr. Daniel J. Baxter, collect: 319-243-4600 days or 319-242-6451 nights. (2)

**FAIRBURY:** Family practice physician—Excellent opportunity to join General Practice Physician planning retirement in two years. Cross coverage is available in this thriving rural practice. Fairbury Hospital, a 112-bed JCAH accredited hospital, offers income guarantees and other financial assistance. **Contact:** Kate H. Dickey, Director, Physician Recruitment, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739. (815-692-2346 x215) (4)

**GALESBURG:** Population 35,305. Seat of Knox County, pop. 61,300. An attractive college community 180 miles from Chicago. Near Peoria, Quad-Cities. Diversified industry and agribusiness. Full selection of educational, cultural and recreational activities. For information on practice opportunities, **CONTACT:** David D. Fleming, Vice-President, Galesburg Cottage Hospital, 695 N. Kellogg St., Galesburg 61401. 309/343-8131. (4)

**GENESEO:** Population 8,000, trade area - 29,000. Rich farming area. Downtown office fully equipped. Hospital - ultra modern. 25 miles east of quad cities - population 400,000. Quality community needing a quality physician. **Contact:** Mrs. A. W. Wellstein, 9 Maplewood, Geneseo 61254 (309-944-2530). (2)

**KEWANEE:** 108 bed community hospital involved in an expansion program is interested in recruiting family practitioners to our service area of 35,000 population. Several practice opportunities exist in group or solo practices. The population centers in the service area range from 15,000 in population and less. **Contact** Harold L. Bischoff, Kewanee Public Hospital, 719 Elliott Street, Kewanee 61443 (309) 853-3361. (4)

**LINCOLN:** 20 miles from Southern Illinois University School of Medicine in Springfield and halfway between St. Louis and Chicago on I55. Need two family practice physicians for growing practice. Office facilities available with 10 man medical group. **Contact** Mary Richter, 311 Eighth, Lincoln 62656. (217/732-9681). (4)

**MACOMB:** GP/FP 12 month contract. University health service. Outpatient clinic. No OB or surgery. Fringes include hospitalization, paid vacation, retirement, etc., approximately 11,000 students - city of 23,000. Competitive negotiable income. EOE/AA employer. **Contact:** C. E. Hughes, M.D., Dir, BEU Health Center, Western IL Univ. Macomb 61455 (309-833-2734) (2)



**MARSHALL:** Population 4,000. County seat of Clark County. Rural community. Comparatively new medical center with available space for 4 doctors. Presently have 2 doctors. Facility fully equipped with lab, x-ray, therapy, emergency room, pharmacy. Located 17 miles from three major hospitals. Have excellent school system and recreational facilities. **CONTACT:** Donald B. Smitley, Admin., 410 N. 2nd St., P.O. Box 219, Marshall 62441, 217-826-2358. (4)

**STERLING:** Progressive 16 physician multispecialty clinic seeks physicians in the following specialties: otolaryngology, general surgery, urology, and OB-GYN. Contact: David Benett, Clinic Manager, Sterling Rock Falls Clinic, Ltd., 101 E. Miller Road, Sterling, 61081 (815-625-4790). (2)

**SULLIVAN:** Population 5,000. New medical center with complete office and ancillary services available. Near universities and colleges. All recreational facilities nearby. **CONTACT:** Sandra Elder, 2 W. Adams, Sullivan 61951 (217) 728-8316 or (217) 728-4186. (4)

**WATSEKA:** Population service area 35,000. Opening for orthopedic surgeon. 23 physicians on staff at present. 85 miles from Chicago in rural area, 160 bed hospital. Within one hour drive of major universities. Very liberal financial package available first year. Contact Paul F. Wenz, 200 Fairman Street, Watseka 60970. (815) 432-5201. (4)

## 1982 FAMILY PRACTICE UPDATE

*Chicago, June 21-25*

Seventh Annual Review Course

*Presented by*

Department of Family Practice

Rush-Presbyterian-St. Luke's

Medical Center

Chicago, Illinois

A rigorous clinical update on practical problems in Family Practice. Register for week review or individual days: Women's Health, Pediatrics, Older Adult, Adult and Other Disciplines. This course is acceptable for up to 30 hours of prescribed credit by AAFP and AMA Category 1.

For further information, contact Barb Trejo, RPSLMC, Office of Continuing Education, 600 So. Paulina, Chicago, 60612, (312) 942-7095. Hotel arrangements on Chicago's Gold Coast; access to Chicago's East Bank Club facilities; packets and special spouse programs available.

## Associate Director Family Practice Residency Program

MacNeal Memorial Hospital, a 427-bed Chicago Area community hospital, one of the nation's pioneers in the field of Family Practice, is now seeking a strong, academically oriented Family Practitioner to join their academic management team as Associate Director, Family Practice Residency Program.

Responsibilities will include the administration of the Family Practice Center and coordination of staff activities, supervision of undergraduate clerkship programs and day-to-day involvement in the guidance and supervision of Family Practice Residents. The Associate Director will also work closely with the Director in the design and development of programs, and grant and budget preparation, and in the Director's absence will have primary program responsibility. To qualify candidates must have—

- Board Certification in Family Practice
- Over 3 years of practitioner (clinical) experience
- The preparation, interest and resourcefulness of a dedicated Educator
- Excellent communication and interpersonal skills needed to interface with faculty, staff and residents
- Strong personal and professional motivation
- Demonstrated ability in the area of program development and design

If you're aggressive, and excited by the fast paced environment of a progressive medical teaching environment, consider the MacNeal Opportunity where you can combine the best of all professional worlds—Clinical, Administrative and Academic. MacNeal recognizes and rewards excellence with an outstanding salary and benefits package. (Candidates will be eligible for faculty appointment at the University of Illinois, Abraham Lincoln School of Medicine.) To apply send *curriculum vitae* to Dr. Kenneth Kessel, c/o Audrey Meadows, MacNeal Memorial Hospital, 3249 South Oak Park Avenue, Berwyn, Illinois 60402.

## Faculty Member Family Practice Program

The Black Hawk Area Medical Education Foundation is recruiting a Board Certified Family Physician to join its Family Practice Residency Program in Waterloo, Iowa. The program is community-based, affiliated with the University of Iowa College of Medicine, and part of the Iowa Network of Family Practice Residency Programs. The Waterloo metropolitan area has 125,000 people, four hospitals, and is well represented in the medical specialties.

Applicants should have an M.D. degree, be eligible for licensure in Iowa, and should have several years of practice experience. Major duties include teaching residents in all aspects of patient care, including obstetrics, and also providing patient care. Other duties include some program administration and assisting in research from time to time.

A salary in the range of \$60,000 per year with an additional 20% fringe benefit package is offered. Other fringe benefits relating to retirement, moving expenses, and continuing education are provided.

Please submit your resume to: Charles A. Waterbury, M.D., Program Director, Black Hawk Area Medical Education Foundation, 441 East San Marnan Drive, Waterloo, Iowa 50702, (319) 234-4419.

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# LIFE AFTER 65... IN THE 1980's

## *More active than ever*

People are not only living longer these days, they're functioning better and leading more productive lives. A growing number of persons eligible for retirement are staying in the work force, some even venturing into second careers.

Those who do retire often choose active hobbies and investigate "late start" educational programs.

## *Medical advances have expanded the physically healthy years*

Significant medical advances, innovative methods of treatment, the development of new medications—these have played important roles in improving the quality of life for the older generation. In addition, there are now many social services available to help the elderly cope with their problems and enrich their lives.





***As with any age group, some cannot cope***

But advancing years do bring increased problems and, frequently, increased anxieties as well. Although many elderly people can cope with these anxieties—and can adapt to the inevitable changes of the later years—there are many who cannot. Their anxiety and psychic tension reach levels that can reduce their coping capacities, perhaps bringing productivity to a halt. Fortunately, the supportive care and empathy of the family physician go far to enhance the emotional well-being of these patients—and to ensure that life after 65 continues as active as before.

For some excessively anxious patients, pharmacological support may be indicated. Because of its special advantages and low-dose effectiveness, Valium (diazepam/Roche) 2 mg is an excellent choice for the elderly patient. Side effects more severe than drowsiness, fatigue and ataxia are rare and seldom serious. As with all CNS-acting agents, patients should be cautioned about drinking alcoholic beverages while on Valium therapy and engaging in potentially hazardous activities such as driving or operating machinery.

*When the emotional problem  
is excessive anxiety*

**VALIUM<sup>®</sup> <sub>IV</sub>**  
diazepam/  
Roche  
2-mg scored tablets



Please see summary of  
product information on following page.



# VALIUM<sup>®</sup> diazepam/ Roche

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy). The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours; then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**How Supplied:** For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100\* and 500; \* Prescription Paks of 50, available in trays of 10; \* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25;† and in boxes containing 10 strips of 10.

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## PRACTICAL VENTILATOR MANAGEMENT

Saturday, April 17, 1982 at Loyola University Medical Center, Room 2706, 2160 South First Avenue, Maywood, Illinois 60153.

Meets the criteria for 6 hours in Category I for the Accreditation Council for Continuing Medical Education (ACCME).

### *Sponsored by*

Loyola University of Chicago, Stritch School of Medicine, Division of Continuing Medical Education and the Pulmonary Section of the Department of Medicine and the Chicago Lung Association.

The seminar will present actual cases, with emphasis on practical management and will be geared to the level of pulmonary fellow but intended for practicing physicians. The fee for the seminar is \$35.00 and will include lunch, coffee break, and parking. Registration will be open to all physicians, but limited to 157.

Make Checks Payable to: The Division of Continuing Medical Education—Loyola University Medical Center.

For additional information contact Linda Gunzburger, Ph.D., Director, Division of Continuing Medical Education, Loyola University, Stritch School of Medicine, 2160 S. First Ave., Maywood, IL 60153, (312) 531-3237.

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# Guide to Continuing Medical Education

## APRIL

### Internal Medicine

#### Lake County Medical/Surgical Seminar

**For:** MD's, Surgeons. Seminar, April 14, Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan 60085. **Reg. deadline:** 4/12. **Fee:** \$5. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312/578-2555.

### Medicine

#### Tomorrow's Cardiology—Today

**For:** MD's. Symposium, April 29, 1:00 p.m., Lincoln. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$35 pre. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Obstetrics/Gynecology

#### Obstetric Emergencies

**For:** MD's. Symposium, April 14, 6:00 p.m., Highland. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$35 pre. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Oncology

#### Evaluation & Management of Patients with Breast Cancer

**For:** FP's, Internists. Lecture, April 14, 10:00 a.m., Chicago. **Sponsor:** American Cancer Society, Chicago Unit, 37 S. Wabash, Chicago 60603. **Cosponsor:** Rush Medical College. **Reg. deadline:** none. **Fee:** \$25. **Reg. limit:** 100. **Credit:** Category 1, 5 hours; AAFP, 5 hours. **Phone:** 312/372-0471.

### Pediatrics

#### Downstate Illinois Pediatric Society Symposium

**For:** MD's. Symposium, April 3-4, Springfield. **Sponsor:** Illinois Pediatric Society, 320 Armstrong Ave., Peoria 61603. **Cosponsor:** SIU School of Medicine. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1.

### Psychiatry

#### Understanding Childhood Depression

**For:** MD's, Psychologists. Lectures, April 12, Radisson Chicago Hotel. **Sponsor:** Community Guidance Center, Mercy Hospital Medical Center, Stevenson Expressway at King Drive, Chicago 60616. **Reg. deadline:** 3/29. **Fee:** \$50. **Credit:** Category 1, 6 hours.

### Sleep Disorders

#### Identifying Sleep Problems—Psychological & Organic

**For:** MD's. Lecture, April 30, Chicago. **Speaker:** Rosalind Cartwright, PhD. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Reg. deadline:** none. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Sharon Smith. **Phone:** 312/883-2112.

### Vascular Disease Update

**For:** MD's. Symposium, April 17, 1:00 p.m., Olney. **Sponsor:** SIU School of Medicine, P. O. Box 3926, CME, Springfield 62708. **Reg. deadline:** none. **Fee:** \$35 pre. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## MAY

### Anesthesiology

#### Midwest Anesthesiology Conference

**For:** MD's. Lectures, May 6-8, Chicago Marriott Hotel. **Sponsor:** Illinois Society of Anesthesiologists, c/o Michael Reese Hospital, 29th St. and Ellis Ave., Chicago 60616. **Reg. deadline:** none. **Reg. limit:** none. **Credit:** Category 1, 17-23 hours. **Contact:** William Gottschalk, MD. **Phone:** 312/942-6503.

### Anesthesiology

#### Regional Anesthesia

**For:** Anesthesiologists. Lecture, May 10 (5 days), Chicago. **Speaker:** Alan Winnie, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 20. **Credit:** Category 1, 45 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Anesthesiology

#### Specialty Review in Anesthesiology

**For:** Anesthesiologists. Lecture, May 16 (6 days), Chicago. **Speaker:** Alan Winnie, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$525. **Reg. limit:** 300. **Credit:** Category 1, 52 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Cardiology

#### Clinical Management of Coronary Disease & Dual-Mode Exercise Testing

**For:** GP's, FP's, Internists. Seminar, May 14-15, Hyatt Regency, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **Contact:** Doris Price. **Phone:** 800-525-8651 X 123.

### Cardiovascular Emergencies

#### Annual Scientific Session

**For:** MD's, RN's. Lecture/workshop, May 13-14, Ramada Convention Center, Champaign. **Sponsor:** American Heart Assn., 1181 N. Dirksen Pkwy., Springfield 62708. **Cosponsor:** SIU School of Medicine. **Reg. deadline:** 5/6. **Fee:** \$65. **Reg. limit:** 250. **Credit:** Category 1, 10 hours; AAFP Elective, 10 hours. **Contact:** A. Paul Naney, MD. **Phone:** 217/525-1350.

#### 34th Annual Postgraduate Seminar

**For:** FP's. Annual Meeting, May 23-27, Hyatt Regency, Chicago. **Sponsor:** Illinois Academy of Family Physicians. 1200 Harger Rd., Suite 405, Oak Brook 60521. **Fee:** Member, \$0; Non-Member, \$25. **Reg. limit:** none. **Credit:** Category 1, 12-22 hours; AAFP Prescribed, 12-22 hours. **Contact:** H. Marchmont-Robinson, MD. **Phone:** 312/325-8502.

#### Caring for the Older Patient

**For:** MD's. Symposium, May 11, 7:00 p.m., Effingham. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$30 pre. **Reg. limit:** none. **Credit:** Category 1, 3 hours; AAFP Prescribed, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Internal Medicine

#### Lake County Medical/Surgical Seminar

**For:** MD's. Seminar, May 19, Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan 60085. **Reg. limit:** none. **Reg. deadline:** 5/17. **Fee:** \$5. **Credit:** Category 1, 4 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312/578-2555.

### Medical Education

#### Problem Based Learning in Medical Education

**For:** MD's. Workshop, May 10-14, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Medicine

#### First Annual Oncology Symposium

**For:** MD's. Symposium, May 7-8, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Medicine

#### Cardiology Update

**For:** MD's. Symposium, May 22, 1:00 p.m., Marion. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$35 pre. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Medicine

#### What is Happening in Cardiology

**For:** MD's. Symposium, May 28, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Medicine

#### Chronic Gastrointestinal Complaints

**For:** MD's. Symposium, May 5, 6:00 p.m., Maryville. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$35 pre. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Neuroradiology

#### 1982 Neuroradiology Review Course

**For:** General Radiologists, Neuroradiologists, Neurosurgeons. Course, May 1-2, Drake Oakbrook. **Sponsor:** Loyola University Medical Center, CME, 2160 S. First Ave., Maywood 60153. **Fee:** \$125; \$75, Residents. **Credit:** Category 1, 15 hours. **Contact:** Behrooz Azar-Kia, MD. **Phone:** 312/531-3928.

### OB/GYN

#### Reproductive Endocrinology

**For:** MD's. Symposium, May 15, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$80 pre. **Reg. limit:** none. **Credit:** Category 1, 6 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### OB/GYNE

#### Specialty Review in Ob-Gyne

**For:** Obstetricians, Gynecologists. Lecture, May 17 (5 ½ days), Chicago. **Speaker:** M. LeRoy Sprang, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$425. **Reg. limit:** 300. **Credit:** Category 1, 44 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## OB/GYNE

**Ninth Annual Symposium on Obstetrics and Gynecology**  
**For:** MD's. Symposium, May 13-14, St. Louis, MO. **Sponsor:** CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Reg. deadline:** none. **Fee:** \$150. **Reg. limit:** 150. **Credit:** Category 1, 12 ½ hours; AAFP Prescribed, 12 ½ hours; ACOG, 13 cognates. **Contact:** Loretta Giacoletto. **Phone:** 314/367-9673.

## Oncology

**Overview and Update on Gynecologic Malignancies**  
**For:** Internists, FP's. Gynecologists. Lecture, May 5, Chicago. **Sponsor:** American Cancer Society, 37 S. Wabash, Chicago 60603. **Cosponsors:** Mt. Sinai Hospital; Rush Medical College. **Reg. deadline:** none. **Fee:** \$25. **Reg. limit:** none. **Credit:** Category 1, 6 hours. **Phone:** 312/372-0471.

## Psychiatry

**Diagnostic Interview Schedule Training**  
**For:** Psychiatrists. Seminar, May 24-28, St. Louis, MO. **Sponsor:** CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$400. **Reg. limit:** 20. **Credit:** Category 1, 32 ½ hours. **Contact:** Loretta Giacoletto. **Phone:** 314/454-3873.

## Radiology

**Specialty Review in Radiology**  
**For:** Radiologists. Lecture, May 17 (5 days), Chicago. **Speaker:** Rogelio Moncada, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

**Trauma Surgery: in the ER, OR, and ICU**  
**For:** General Surgeons. Symposium, May 12-14, Chicago. **Sponsors:** U of I College of Medicine; Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Reg. deadline:** 5/12. **Fee:** \$275. **Reg. limit:** 300. **Credit:** Category 1, 19 hours. **Contact:** Robert Baker, MD. **Phone:** 312/996-6765.

## Surgery

**Care of the Amputee Patient—A Multidisciplinary Approach**  
**For:** MD's. Symposium, May 1, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Surgery

**Sports Injuries IV**  
**For:** MD's. Symposium, May 15, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$80 pre. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Surgery

**Pediatric Aspects of Head & Neck Surgery**  
**For:** MD's. Symposium, May 21-22, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 10 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Surgery

**Advances in Surgery**  
**For:** General & Specializing Surgeons. Lecture, May 3 (5 days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$375. **Reg. limit:** 100. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker. **Phone:** 312/733-2800.

## Surgery

**Fiberoptic Esophagogastric Endoscopy**  
**For:** Surgeons, Internists. Lecture, May 3 (2 ½ days), Chicago. **Speaker:** C. Thomas Bombeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

### Principles of GI Endoscopy

**For:** Surgeons. Lecture, May 26 (2 ½ days), Chicago. **Speaker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$250. **Reg. limit:** 100. **Credit:** Category 1, 20 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## JUNE

## Diabetes

### Diabetes Mellitus—1982

**For:** Primary care physicians. Symposium, June 4-5, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** TBA. **Reg. limit:** none. **Credit:** Category 1; AAFP Prescribed, AOA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Emergency Care

### Cardio-Pulmonary Resuscitation Update

**For:** MD's. Lecture/demonstration, June 25, 11:00 a.m., Oak Park. **Sponsor:** CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Charles Weigel, MD. **Phone:** 312/366-7870.

## Family Medicine

### Specialty Review in Family Practice

**For:** FP's. Lecture, June 1 (11 days), Chicago. **Speaker:** Harry Marchmont-Robinson, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$600. **Reg. limit:** 200. **Credit:** Category 1, 98 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Family Practice

### Practical Office Oncology

**For:** FP's. Lecture, June 11 (1 ½ days), Chicago. **Speaker:** John Merrill, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$175. **Reg. limit:** 90. **Credit:** Category 1, 12 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Family Medicine

### 1982 Family Practice Update

**For:** MD's. Course, June 21-25, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, CME, 600 S. Paulina, Chicago 60612. **Fee:** \$300. **Reg. limit:** none. **Credit:** Category 1, 30 hours; AAFP Prescribed, 30 hours. **Contact:** Vickie O'Sullivan. **Phone:** 312/942-7119.

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## Internal Medicine

### Problem Solving in Lung Disease: A Practical Approach

**For:** MD's. Course, June 2-4, Chicago. **Sponsor:** American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. **Cosponsors:** U of Chicago; Michael Reese Hospital and Medical Center. **Fee:** \$170-\$300. **Reg. limit:** 100. **Credit:** Category 1. **Contact:** Maxine Topping. **Phone:** 800/523-1546.

## Medicine

### Infectious Disease—What's New?

**For:** MD's. Symposium, June 3, 3:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$40 pre. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## OB/GYN

### Obstetrical Events and Neonatal Brain Injury

**For:** MD's. Conference, June 24-25, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** \$180. **Reg. limit:** none. **Credit:** Category 1, 12 hours; ACOG credit applied for; AOA, 12 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Pharmacology

### New Therapeutics in Cardiology and Infectious Diseases

**For:** Primary care physicians, Cardiologists. Symposium, June 10-11, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, TBA; AAFP, TBA; AOA, TBA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Pulmonary Medicine

### National Board Review in Pulmonary Medicine

**For:** MD's. Seminar, June 21-25, The Palmer House, Chicago. **Speaker:** Reuben Cherniack, MD. **Sponsor:** American College of Chest Physicians, 911 Busse Hwy., Park Ridge 60068. **Reg. deadline:** none. **Fee:** members, \$350; non-members, \$400. **Reg. limit:** none. **Credit:** Category 1, 32 hours. **Contact:** Dale Braddy. **Phone:** 312/698-2200.

## Surgery

### Fluids and Electrolytes

**For:** Surgeons, Internists. Lecture, June 24 (2 ½ days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$250. **Reg. limit:** 90. **Credit:** Category 1, 23 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.



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# REPORT

## FOR *Illinois Physicians*

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### SPRING SERIES OF WORKSHOPS SCHEDULED

The Illinois Blue Cross and Blue Shield Plan's Spring workshop series for medical assistants in downstate Illinois cities will begin in Marion on April 7 and continue through May 26.

The workshops are intended to inform medical assistants in Plan administrative, claims and payment procedures and advise them of changes in Blue Shield benefits and contracts.

Letters of invitation are being sent to physician's offices with the reservation forms. For additional information, please write Mr. John Eisinger, Professional Relations Department, Blue Cross and Blue Shield Plan, 233 North Michigan Avenue, Chicago, Illinois, 60601, or call him at (312) 938-7887.

The following workshops scheduled:

Wednesday	April 7, 1982	Holiday Inn	Marion
Thursday	April 8, 1982	Holiday Inn	Mt. Vernon
Wednesday	April 14, 1982	Holiday Inn	Effingham (A.M. Only)
Thursday	April 15, 1982	Sheraton Inn	Springfield
Wednesday	April 21, 1982	Augustine's	Belleville
Thursday	April 22, 1982	Ramada Inn	Alton (A.M. Only)
Wednesday	April 28, 1982	Holiday Inn	Bloomington
Thursday	April 29, 1982	Ramada Inn	Peoria
Wednesday	May 5, 1982	Ramada Inn	Quincy
Wednesday	May 5, 1982	Clock Tower Inn	Rockford
Thursday	May 6, 1982	Ramada Inn	Ottawa
Wednesday	May 12, 1982	Holiday Inn	Decatur
Thursday	May 13, 1982	Ramada Inn	Champaign
Wednesday	May 19, 1982	Holiday Inn	Moline
Thursday	May 20, 1982	Sheraton Inn	Galesburg
Wednesday	May 26, 1982	Bradley Holiday Inn	Kankakee (AM Only)



# REGULATORY AGENCIES APPROVE CONSOLIDATION

The consolidation of the Rockford Blue Cross Plan and the Chicago-based Blue Cross and Blue Shield Plan, announced in the January issue of *IMJ*, has been completed with the approval of legal requirements by regulatory agencies.

“The consolidation of our two organizations represents a big step forward in our joint efforts to provide quality, accessible and cost effective health care services to all of our subscribers in Illinois,” said S. Martin Hickman, president of the Chicago-based Plan.

“The consolidation will serve to broaden the base of the merged corporation, while minimizing the impact of adverse health care trends,” Hickman continued. “It will also allow us to better meet the competition from commercial insurers as well as lessen any consumer misunderstanding of Blue Cross and Blue Shield service caused by two separate Plans’ operating throughout the state.”

The Rockford office will continue to operate as a full service office. Operations, policies and procedures of both organizations will be reviewed to make sure their strengths are utilized properly.

“With the consolidation of our Plans, we are able to present a united system to the people of Illinois and can proceed with the business of proving the best health care protection and services to our subscribers,” Hickman added.

Currently, the consolidated Plans represent the fourth largest Blue Cross and Blue Shield operation in the nation with nearly three million subscribers.

## 12 Freestanding Ambulatory Facilities in Program

There are now 12 Freestanding Ambulatory Surgical Facilities participating in the Illinois Blue Cross and Blue Shield Plan’s Ambulatory Surgery Program.

Facilities recently added to the program include; Am-Surg of Joliet, Chang’s Medical Arts Surgi-Center in Maryville, Hawthorn Place Surgical Center in Libertyville, Metro Surgical Center of Chicago and One Day Surgery Center in Belleville.

Other facilities in the program are; the Albany Women’s Medical Center of Chicago, the Hinsdale Surgical Care Center, Inc., of Hinsdale, the Hugar Surgery Center of Elmwood Park, the Mercy Health Care Center of Justice, Northwest Surgicare of Arlington Heights, Notre Dame Hills Surgical Center of Belleville and Surgicare Center, Inc., of Chicago Heights.

The Illinois Plan has been a proponent of freestanding facilities since the enactment of enabling legislation more than six years ago. The Plan feels facilities of this type provide a means of controlling health care costs without sacrificing patient needs.

Prior to enactment of the legislation, the Plan’s policy was that ambulatory surgery should take place within licensed hospitals, with hospitals making special arrangements to facilitate the care of these patients.

As hospitals began to expand their surgical programs to include procedures that could be performed safely on an ambulatory basis, the Plan encouraged the development of these programs.

Each new freestanding facility approved by the Plan has a contract that includes a Procedure List and Charge Schedule for surgery and operating room services, necessary tests and x-rays.

Blue Cross and Blue Shield members having surgery performed at any of the freestanding facilities are eligible to receive outpatient surgical benefits in accordance with provisions of their benefit programs.

A freestanding ambulatory surgical facility wishing to affiliate with Health Care Service Corporation should submit evidence that the facility and its staff does and will comply with prescribed minimum standards and agrees to periodic evaluation by Health Care Service Corporation to confirm continued compliance.

The Provider Affairs Department should be contacted for further information at 233 North Michigan, Chicago, 60601.

# Medicaid-Medicare-Champus Report

## MMIS CLAIMS PROCESSING PROBLEMS AND SOLUTIONS

The Medicaid Management Information System is a computer network that operates on an edit system which reviews claim accuracy prior to payment. In other words, if a claim is submitted with errors, it will automatically be rejected. Rejected claims are either reported on the remittance advice form or suspended for manual correction by IDPA personnel. A checklist of common errors and how to avoid them follows. Please use this checklist as a guide *before* you submit your MMIS claims to IDPA.

**PROBLEMS: (BOXES 1, 2, 4, 8) — PATIENT NAME, ADDRESS, DATE OF BIRTH AND MEDICAID I.D. NUMBER**

**SOLUTION:** Please ensure that this information is totally correct. If an error appears in any of these boxes, your claim will reject or suspend depending on the nature of the error. Use the information exactly as it appears on the patient's "Green Card."

**IMPORTANT: DO NOT USE THE CASE IDENTIFICATION NUMBER AS THE MEDICAID NUMBER. THE MEDICAID NUMBER IS THE NINE-DIGIT NUMBER ON THE REVERSE SIDE OF THE GREEN CARD.**

**PROBLEM: (BOX 19) — REFERRING PHYSICIAN'S NAME AND PROVIDER NUMBER**

**SOLUTION:** The name and provider number of a physician must be included in these boxes when billing for a consultation or for *only a portion* of obstetrical care. The Provider Number is the State License Number.

**PROBLEM: (BOXES 23F and 24D) — DIAGNOSIS/NATURE OF ILLNESS OR INJURY AND DIAGNOSIS CODE**

**SOLUTION:** A diagnosis code from ICD-9-CM or Appendix A-18 of the *Physicians' Handbook* must be included on each MMIS claim. Failure to code a claim with a diagnosis code will cause the claim to reject. Include a diagnosis code from either of the two sources mentioned above in Box 24D. **DO NOT USE PERIODS, HYPHENS OR OTHER PUNCTUATION.** If a diagnosis code cannot be located to describe the diagnosis— use code 9999 in Box 24D. When code 9999 is used, *a narrative description of the diagnosis is required* in Box 23F.

**PROBLEM: (BOX 24C) — PROCEDURE CODE**

**SOLUTION:** A variety of procedure codes are being reported on MMIS claims. CPT IV is the *only* procedure coding scheme that IDPA will accept on MMIS claims. Use of procedure codes other than CPT IV will cause claims to reject. CPT IV can be obtained by writing: American Medical Association, Order Department-OP 41, 535 North Dearborn Street, Chicago, IL 60610.

**PROBLEM: (BOX 24B) — PLACE OF SERVICE**

Some physicians are not correctly reporting the place where service is provided on the MMIS claim form.

**SOLUTION:** Codes for describing the place of service are listed on the back of the MMIS claim form. Each place of service is preceded by a numerical code and this number is to be reported in Box 24B to describe where medical services were rendered. **DO NOT USE LETTERS IN BOX 24B.**

**PROBLEM: (BOX 30) — YOUR PROVIDER NUMBER**

Some physicians have been reporting incorrect provider numbers to IDPA on the MMIS claim form.

**SOLUTION:** When physicians enroll in MMIS, IDPA certified reenrollment by issuing a document called the Provider Information Sheet. Please review this document and record the provider number on Medicaid claims *exactly* as it is on the provider information sheet. This number is your State License number.

**PROBLEM: (BOX 33) — YOUR EMPLOYER I.D. NUMBER**

Some physicians have reported incorrect information in this section of the claim form.

**SOLUTION:** Box 33 identifies the payee to whom payment for services is to be made. The number to be used in Box 33 is a *single digit number that is shown on the Provider Information Sheet*. These numbers correspond with the payees and addresses listed on the Provider Information Sheet. Physicians who are affiliated with clinics, group practices and other corporations can designate IDPA payments to the desired address by reporting the number (single digit) in Box 33.



**PROBLEM: CONCURRENT CARE**

IDPA will not routinely reimburse two or more physicians for the services provided to a public aid patient on a single day or during the period of a hospitalization.

**SOLUTION:** Reimbursement *may* be made for concurrent care only if both of the physicians involved provide documentation that indicates the medical necessity for such care. The documentation that must accompany the MMIS claim form is the Admission Sheet, Surgical Report, Consultation Report and/or Discharge Summary. IDPA will review each case of concurrent care to determine if the documentation warrants reimbursement by the Department.

**PROBLEM: (BOX 34) — NUMBER OF SECTIONS**

Some claims have been received with either no entry or an inaccurate entry in Box 34.

**SOLUTION:** Box 34 *must* be completed with the number of correctly completed lines in section 24 of the claim form. Lines that are deleted because of an error are *not* included in this count.

**PROBLEM: CONSULTATIONS**

For payment purposes, IDPA considers a consultation to be the entire package of services required to arrive at a recommendation on the patient's condition or mode of treatment. Many consultations are performed on the same day as surgery. In addition, some consultants bill for surgical procedures and/or medical care. Both of these situations will cause a claim to be rejected. IDPA will not provide reimbursement for consultations on the same day as surgery except in traumatic or emergency situations.

**SOLUTION:** Consultations should be billed on a separate claim form. In those situations where consultations may be considered by IDPA to be concurrent care, the consultant should enclose a copy of the consultation reports, and discharge summary with the claim.

**PROBLEM: INITIAL OFFICE VISIT CODES**

These are to be used only one time per patient. Physicians' claims which report more than one initial office visit on the same patient will be rejected.

**SOLUTION:** Please refer to IDPA's *Handbook for Physicians* for guidelines and record keeping requirements when billing initial and subsequent office visits.

**PROBLEM: NEWBORN CARE**

There are special instructions required in order to bill for newborn care.

**SOLUTION:** Physicians providing newborn care should enter the child's name in Box 1. If the child's name is unknown this section may be completed with "Newborn Infant." When billing for newborn care, you must enter the child's birthdate and the *mother's* recipient I.D. number. Claims for newborn care should be mailed to IDPA, Eligibility Monitoring Unit, P.O. Box 4027, Springfield.

## ADDITIONAL COMMENTS

**Handwritten Claims** — Physicians' offices should also be advised that *any* information that is reported on MMIS claims in handwritten form will usually create at least an additional 2-3 weeks of processing time. IDPA will process handwritten claims, but, IDPA personnel must make manual entries of the claim before it can be processed.

**PATIENT ELIGIBILITY** — Often, patients who seek medical care are not eligible recipients of Medical Assistance Program benefits. To safeguard against rejected claims due to patient ineligibility, it may be necessary to determine the status of benefits allowed by IDPA to a recipient. Physicians should check the patient's "Green Card" as eligibility may change on a monthly basis. The general appendix of the *IDPA Medical Assistance Program Handbook for Physicians* includes a listing of the local Public Aid offices in the state. The local Public Aid office may be of assistance to you in accurately determining the eligibility of Public Aid recipients.

In response to numerous requests by ISMS, IDPA has agreed to conduct additional MMIS educational seminars. The seminars will be conducted during the Spring. The specific locations and dates for seminars are currently being arranged by IDPA.

As always, if you or your staff have difficulty in submitting MMIS claims or require clarification of IDPA's policies or procedures, do not hesitate to contact your ISMS Field Representative at (312) 782-1654. Routine MMIS inquiries in Cook County may be directed to Christine Szuflita at the Chicago Medical Society (312) 670-2550.

## MEDICARE

In each calendar year a beneficiary deductible must be satisfied before payment may be made under Medicare Part B. As of January 1, 1982, the deductible is \$75.00 (up from \$60.00). Additionally, as of January 1, 1982, the carryover rule under which deductible expenses incurred during the last three months of a calendar year could also be counted toward the next year's deductible has been eliminated.

# President's Page

## Participation In The Illinois State Medical Society



It is with some apprehension that I now prepare to succeed Dr. Fred Z. White as president and spokesman of the Illinois State Medical Society. He has been an outstanding leader. Few others have discharged their responsibilities to the profession and the public we serve more conscientiously, with such a wealth of pertinent experience and with such good humor.

On behalf of all the members of the Society, it is my privilege to thank Dr. White for his inestimable services, while at the same time extending our hope that he will continue to provide his wise counsel to our officers and staff.

While the president is the member most in the spotlight, it must be remembered that many others have contributed to the successful accomplishment of the varied activities of the Society. Altogether, about 450 members of the Illinois State Medical Society serve on task forces, committees and councils. Without them, organized medicine in Illinois would be an emasculated giant. A grateful "thank you" is due those who have sacrificed their time from professional and social activities, as well as from their families.

An organization is only as strong as the interest and unity of its members in accomplishment of its defined goals. The Illinois State Medical Society's primary objectives are to:

- (a) promote the science and art of medicine;
- (b) protect the public health;
- (c) elevate the standards of medical education;
- (d) unite the medical profession behind these purposes.

These worthy objectives can only be realized completely with the cooperation and participation of all Illinois physicians. While it is obvious that not all can participate fully, membership in the Illinois State Medical Society implies a willingness to be active on our profession's behalf with whatever talents an individual possesses for whatever length of time he can spare from his other activities.

It is lamentable that so many physicians do not choose to join organized medicine at all. They not only shirk their responsibility to support representatives of their profession in administrative and legislative arenas of our state and nation (at the same time benefitting from such representation) but also place the considerable financial burden that these activities engender on the shoulders of their colleagues.

The membership committee is presently devising ways to reach these physicians so that they may be encouraged to lend their support to the only group that represents all aspects of their activities as physicians. I hope that ISMS members will approach those physicians who are not members of organized medicine and bring to their attention the need to have all physicians united behind our worthy goals. ◀

*C. C. Wiggishoff M.D.*

Cyril C. Wiggishoff, M.D., President



# ***HYPERTENSION:***

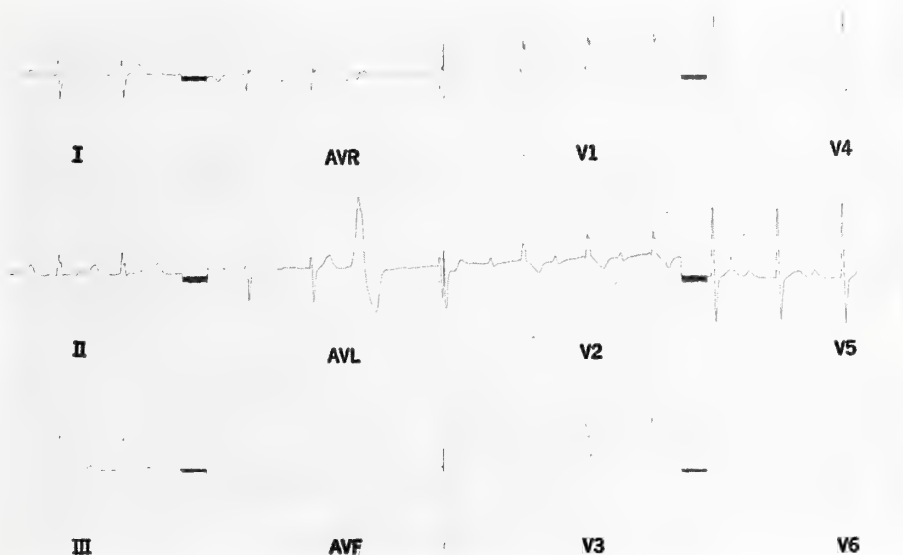


# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a fifty-one year old man with known congenital heart disease. He said he was a "blue baby" and that his childhood activities had been restricted by easy fatigue. He had required a phlebotomy every four to six weeks in the past few years. A cardiac catheterization had been done in 1962 but the results were not available. Now he complained of episodes of palpitations and dyspnea which were becoming more frequent. He also noted occasional chest pressure and left arm numbness.*

*After a severe bout of dyspnea, palpitations, and chest pressure, he came to the emergency service. Physical examination demonstrated a cyanotic man with clubbing of his fingers. Examination of the chest and heart was significant for a posterior thorax systolic thrill, a left sternal border lift, a single second heart sound, and a grade 3/6 systolic murmur heard all over the precordium. His hemoglobin and hematocrit were 17.8 grams and 58.9%, respectively. A chest X-ray demonstrated decreased pulmonary vascularity and clear lung fields otherwise. The ECG is shown. A repeat cardiac catheterization was recommended.*



## Questions:

### 1. The ECG shows:

- Severe right ventricular hypertrophy.
- Right axis deviation in the frontal plane.
- First degree atrioventricular block.
- Left atrial enlargement.
- All of the above.

### 2. The following statement(s) is/are true:

- The history and physical exam presented

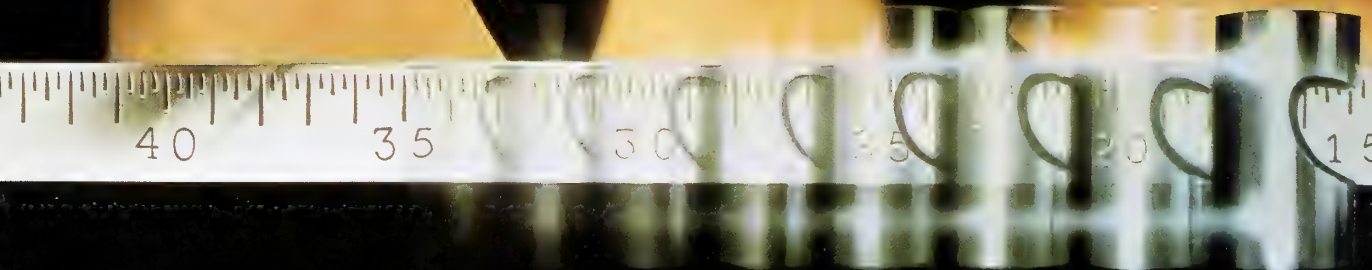
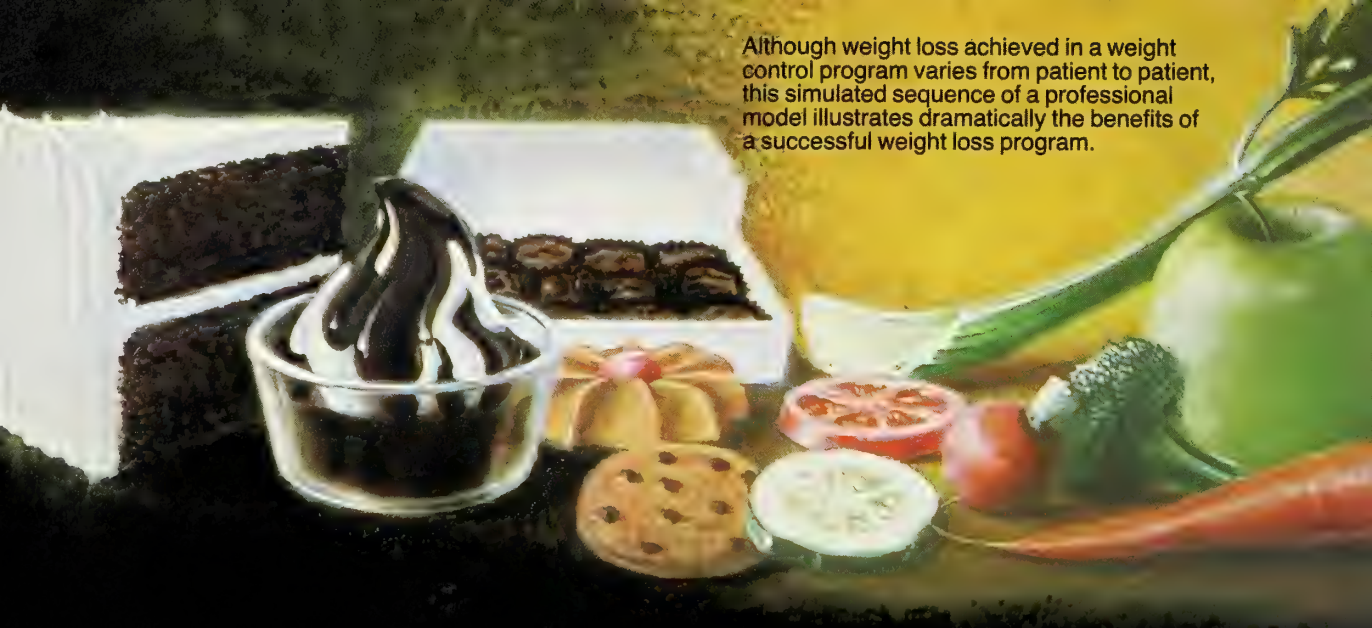
here are compatible with tetralogy of Fallot.

- The average age at death of all untreated patients with this disease is twelve years.
- Tetralogy of Fallot is the most common cyanotic congenital heart disease in adults.
- Congestive heart failure occurs in one-third of adults with tetralogy of Fallot while it is unusual in infants and children with this disease.
- All of the above.

(Continued on page 286)



Although weight loss achieved in a weight control program varies from patient to patient, this simulated sequence of a professional model illustrates dramatically the benefits of a successful weight loss program.



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(Citations provided on request.)

**Comparison of Anorectics**

	Agent	Amine Classification	Half-life <sup>a</sup>	Variety of Dosage Form	Degree of CNS Effects
Low Abuse Potential	Diethylpropion	Tertiary	4-6 hrs.	25 mg tablet, 75 mg controlled-release tablet	Mild euphoria, mild stimulation
	Mazindol	Nonphenylethyl-amine	33-55 hrs.	1 & 2 mg tablet	Mild euphoria, mild stimulation
	Fenfluramine	Secondary	10-30 hrs.	20 mg tablet	Moderate sedation (mild to moderate depression, a side effect, is also sometimes designated as a CNS effect)
	Phentermine	Primary	19-24 hrs.	8 & 37.5 mg tablet, 8, 15 & 30 mg capsule, 15 & 30 mg capsule (resin complex), 15 & 30 mg timed release capsule	Mild euphoria, moderate stimulation
High Abuse Potential	Phenmetrazine	Secondary	7-9 hrs.	25 mg tablet, 50 & 75 mg prolonged action tablet	Marked euphoria, marked stimulation
	Amphetamine	Primary	10-30 hrs.	Various	Marked euphoria, marked stimulation

<sup>a</sup>Delayed release characteristics of certain dosage forms must also be taken into account.

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(diethylpropion hydrochloride USP)

**Tenuate Dospan®<sup>IV</sup>**  
(diethylpropion hydrochloride USP)

**controlled-release**

**AVAILABLE ONLY ON PRESCRIPTION**

Brief Summary

**INDICATION:** Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

**CONTRAINDICATIONS:** Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines; glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

**WARNINGS:** If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

**PRECAUTIONS:** Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

**ADVERSE REACTIONS:** **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

**DOSAGE AND ADMINISTRATION:** Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in the evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in the morning. Tenuate is not recommended for use in children under 12 years of age.

**OVERDOSAGE:** Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenitamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

**Reference:** 1. Abramson R, Garg M, Cioffari A, and Rotman PA: An Evaluation of Behavioral Techniques Reinforced with an Anorectic Drug in a Double-Blind Weight Loss Study. J Clin Psych 41:234-237, 1980.

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999 Executive Pkwy. / P.O. Box 27352 / St. Louis, Missouri 63141

*Illinois Medical Journal*

# Obituaries

**\*\*Ashby, John S.**, Evanston, died January 5, 1982, at the age of 83. Dr. Ashby was a 1926 graduate of Rush Medical College.

**\*\*Bruni, Filippo**, Chicago, died December 17, 1981, at the age of 86. Dr. Filippo was a 1921 medical school graduate from Napoli, Italy.

**\*Crew, Morton R.**, Decatur, died January 15, 1982, at the age of 63. Dr. Crew was a 1943 medical school graduate.

**Finegan, Thomas F.**, Oak Lawn, died December 30, 1981 at the age of 93.

**\*\*Hamilton, Edwin S.**, Kankakee, died February 26, 1982, at the age of 91. Dr. Hamilton had served as ISMS president, 1962, and chairman, AMA Board of Trustees, 1957. He was a founding member of the World Medical Association, serving for ten years on its board of directors. He also served for twelve years as chairman of the Illinois Medical Examining Committee, which governs physician licensure.

Dr. Hamilton practiced medicine in Kankakee for more than 60 years, where he served as first chief of staff at St. Mary's Hospital and president of the Kankakee County Medical Society. He served as alternate delegate to the AMA, 1932-36, a member of the AMA House of Delegates, 1936-1948, and member of the AMA Board of Trustees, 1948-1958.

Upon his 1973 retirement, ISMS established the Edwin S. Hamilton Interstate Teaching Award, given annually in his honor to an outstanding medical teacher chosen by the ISMS Council on Education and Manpower. Other professional affiliations included the Interstate Postgraduate Medical Association of North America and the International College of Surgeons.

Also a civic leader, he was the recipient of the first life membership awarded by the Kankakee Kiwanis Club, of which he was a past president and charter member.

Dr. Hamilton received his medical degree from Rush Medical College in 1912 and interned at Cook County Hospital at the age of 22.

He is survived by his wife, Zona, a son, Edwin Clark, a daughter, Helen Jane Schillinger and two grandchildren.

**\*Lucas, Nicholas**, Joliet, died December 30, 1981 at the age of 76. Dr. Lucas was a 1935 graduate of the Chicago Medical School. He was also a past president of the Will-Grundy County Medical Society.

**\*Miller, Milton**, Chicago, died January 13, 1982, at the age of 65. Dr. Miller was a 1944 graduate of the Chicago Medical School.

**Pick, Alfred**, Chicago, died January 8, 1982, at the age of 74.

**Reynolds, John Todd**, Chicago, died October 24, 1981, at the age of 73. Dr. Reynolds was a 1933 graduate of the University of Illinois Abraham Lincoln School of Medicine.

**\*\*Rimmerman, Abraham B.**, Chicago, died June 18, 1981. Dr. Rimmerman was a 1912 graduate of the University of Iowa College of Medicine.

**\*\*Sneller, Charles D.**, Peoria, died January 16, 1982 at the age of 90. Dr. Sneller was a 1922 graduate of the University of Minnesota Medical School, Minneapolis and a former president of the Peoria County Medical Society.

*\*Indicates ISMS Member*

*\*\*Indicates member of the ISMS Fifty Year Club*

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**AND YET  
CAN DO  
TOO MUCH.**



# INCREASE CONTROL WITHOUT INCREASING POTASSIUM PROBLEMS.

## **A dependable means to long-term blood pressure control.**


Many times, a diuretic alone can't keep hypertension in check. *INDERIDE*, however, can pick up where thiazide therapy leaves off.

The combination of propranolol HCl, the world's most trusted beta blocker, and hydrochlorothiazide, the standard among diuretics, enables *INDERIDE* to exert an additive antihypertensive effect.<sup>1,2</sup> In fact, a propranolol/hydrochlorothiazide regimen maintained blood pressure below 90 mm Hg in 81.8% to 86.4% of patients followed for 6 to 18 months of therapy.<sup>1</sup>

## **Low thiazide dosage means reduced risk of hypokalemia.**

When thiazides are prescribed in doses greater than 50 mg/day, the potential for hypokalemia increases substantially. What's more, the greater the fall in serum K<sup>+</sup>, the greater the risk of hypokalemia-induced PVCs.<sup>3,4</sup>

With *INDERIDE*, the additive hypotensive effect of propranolol HCl allows the effective dose of hydrochlorothiazide to be kept low (25 mg b.i.d.). And by lowering the daily dose of diuretic, *INDERIDE* also lowers the potential for diuretic-induced side effects. Potassium problems are less likely to occur—yet blood pressure can be controlled consistently.



# **INDERIDE<sup>®</sup>**

Each tablet contains *INDERAL<sup>®</sup>*  
(propranolol HCl) 40 mg or 80 mg,  
and hydrochlorothiazide 25 mg

# **B.I.D. 40/25 80/25**

## **When you know you need more than a thiazide.**

Please see Brief Summary of Prescribing Information on following page.



BRIEF SUMMARY  
(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

## INDERIDE®

BRAND OF  
propranolol hydrochloride  
(INDERAL®)  
and hydrochlorothiazide

No. 474—Each IINDERIDE®-40/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	40 mg
Hydrochlorothiazide	25 mg
No. 476—Each IINDERIDE®-80/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	80 mg
Hydrochlorothiazide	25 mg

**WARNING:** This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

**DESCRIPTION:** IINDERIDE combines two antihypertensive agents: IINDERAL (propranolol hydrochloride), a beta-adrenergic blocking agent, and hydrochlorothiazide, a thiazide diuretic-antihypertensive.

**INDICATION:** IINDERIDE is indicated in the management of hypertension. (See boxed warning.)

**CONTRAINDICATIONS:** Propranolol hydrochloride (INDERAL®): Propranolol hydrochloride is contraindicated in: 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

**Hydrochlorothiazide:** Hydrochlorothiazide is contraindicated in patients with anuria or hypotension to this or other sulfonamide-derived drugs.

**WARNINGS:** Propranolol hydrochloride (INDERAL®): CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy propranolol therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

**USE IN PREGNANCY:** Propranolol hydrochloride (INDERAL®): The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

**Hydrochlorothiazide:** Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**Nursing Mothers:** Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

**PRECAUTIONS:** Propranolol hydrochloride (INDERAL®): Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope, attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

**Hydrochlorothiazide:** Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

**ADVERSE REACTIONS:** Propranolol hydrochloride (INDERAL®): Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesias of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

**Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation in time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

**Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with arthralgia and sore throat, laryngospasm and respiratory distress.

**Respiratory:** bronchospasm.

**Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**Hydrochlorothiazide:** Gastrointestinal: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatic sludge, sialadenitis.

**Central Nervous System:** dizziness, vertigo, paresthesias, headache, xanthopsia.

**Hematologic:** leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

**Cardiovascular:** orthostatic hypotension (may be aggravated by alcohol, barbiturates, narcotics).

**Hypersensitivity:** purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reaction.

**Other:** hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

**DOSEAGE AND ADMINISTRATION:** The dosage must be determined by individual titration (see boxed warning).

Hydrochlorothiazide is usually given at a dose of 50 to 100 mg per day. The initial dose of propranolol is 40 mg twice daily and it may be increased gradually until optimum blood pressure control is achieved. The usual effective dose is 160 to 480 mg per day.

One to two IINDERIDE tablets twice daily can be used to administer up to 320 mg of propranolol and 100 mg of hydrochlorothiazide. For doses of propranolol greater than 320 mg the combination products are not appropriate because their use would lead to an excessive dose of the thiazide component.

When necessary, another antihypertensive agent may be added gradually beginning 50 percent of the usual recommended starting dose to avoid an excessive fall in blood pressure.

**OVERDOSEAGE OR EXAGGERATED RESPONSE:** The propranolol hydrochloride (INDERAL®) component may cause bradycardia, cardiac failure, hypotension, or bronchospasm.

The hydrochlorothiazide component can be expected to cause diuresis. Lethargy of varying degree may appear and may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function, and in the absence of significant serum electrolyte changes or dehydration. The mechanism of central nervous system depression with thiazide overdosage is unknown. Gastrointestinal irritation and hypermotility can occur temporary elevation of BUN has been reported, and serum electrolyte changes could occur especially in patients with impairment of renal function.

**TREATMENT:** The following measures should be employed. GENERAL—If ingestion is recent, may have been recent, evacuate gastric contents taking care to prevent pulmonary aspiration. BRADYCARDIA—Administer atropine (0.25 to 1.0 mg). If there is no response to beta blockade, administer isoproterenol cautiously. CARDIAC FAILURE—Digitalization and diuretics. HYPOTENSION—Vasopressors, e.g., levaterenol or epinephrine. BRONCHOSPASM—Administer isoproterenol and aminophylline. STUPOR OR COMA—Administer supportive therapy as clinically warranted. GASTROINTESTINAL EFFECTS—Though usually of short duration, these may require symptomatic treatment. ABNORMALITIES IN BLOOD AND/OR SERUM ELECTROLYTES—Monitor serum electrolyte levels and renal function. Institute supportive measures as required individually to maintain hydration, electrolyte balance, respiration, and cardiovascular-renal function.

**HOW SUPPLIED:** No. 474—Each IINDERIDE®-40/25 tablet contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 476—Each IINDERIDE®-80/25 tablet contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

**References:** 1. Veterans Administration Cooperative Study Group on Antihypertensive Agents: J.A.M.A. 237:2303 (May 23) 1977. 2. Bravo, E.L., Tarazi, R.C., and Dustan, H.P.: N. Engl. J. Med. 292:66 (Jan. 9) 1975. 3. Hollifield, J.W., and Slaton, P.E.: Acta Med. Scand. [Suppl.] 647:67, 1981. 4. Holland, O.B., Nixon, J.V., and Kuhnert, L.: Am. J. Med. 70:762 (Apr.) 1981.

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# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This month's Viewbox was contributed by David Okrent, M.D., Loyola University Medical Center, Maywood.*

*This 37-year-old woman was on clindamycin therapy for an infection following hysterectomy for benign leiomyoma of the uterus. She subsequently developed crampy abdominal pain, increasing abdominal girth, and bloodless diarrhea. Plain film examination of her abdomen is shown above.*



**Figure 1**

## Your Diagnosis?

1. Toxic megacolon
2. Pseudomembranous colitis
3. Mechanical colon obstruction
4. Colonic ischemia

*(Continued on page 289)*



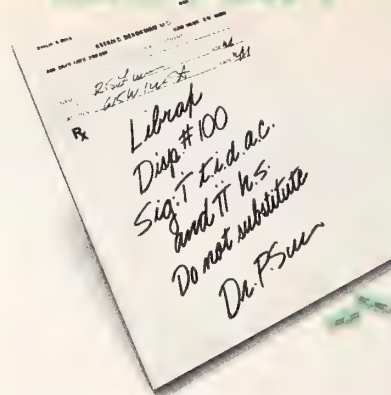
Specify  
Librax®

## Clinics for Crippled Children Listed for May

Forty-one clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 29 general clinics, 10 cardiac clinics, one for children with myelodysplasia and one for children with scoliosis. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- 3 Peoria Myelodysplasia - St. Francis Medical Ctr.
- 4 Belleville - St. Elizabeth Hospital
- 4 Park Ridge General - PM - Lutheran General Hospital
- 4 Park Ridge Cardiac - AM - Lutheran General Hospital
- 4 Wheaton - Marianjoy Rehabilitation Hosp.
- 5 Cairo - Southern Seven Health Dept.
- 6 Springfield General - Memorial Med. Bldg.
- 6 Sterling - Community General Hospital
- 6 Effingham - St. Anthony Memorial Hosp.
- 6 Hinsdale - Hinsdale Sanitarium
- 6 Lake County Cardiac - Victory Mem. Hosp.
- 7 Division Cardiac - U. of I. at the Medical Center
- 10 Peoria Cardiac - St. Francis Medical Center
- 10 Maywood (Ortho/Ped/Neuro) - Loyola Medical Center
- 10 Chicago Heights Cardiac - St. James Hosp.
- 11 East St. Louis - Community Hospital
- 11 Peoria General - St. Francis Med. Center
- 12 Champaign-Urbana - McKinley Health Service Center
- 12 Chicago Heights General - St. James Hosp.
- 12 Joliet - St. Joseph's Hospital
- 13 Macomb - McDonough Health Department
- 13 Pittsfield - Illini Hospital
- 13 Kankakee General - St. Mary's Hospital
- 13 Aurora Cardiac - Mercy Center for Health Care Services
- 14 Hinsdale Scoliosis - Hinsdale Sanitarium
- 17 Maywood - (Ortho/Ped) - Loyola Medical Center
- 18 Rock Island General - Moline Public Hospital
- 18 Decatur - Decatur Memorial Hospital
- 18 Alton - Alton Memorial Hospital
- 19 Evergreen Park - Little Company of Mary Hospital
- 20 Rockford - Rockford Memorial Hospital
- 20 Centralia - St. Mary's Hospital
- 20 Elmhurst Cardiac - Memorial Hospital of DuPage County
- 21 Kankakee Cardiac - St. Mary's Hospital
- 24 Peoria Cardiac - St. Francis Medical Ctr.
- 24 Chicago Heights Cardiac - St. James Hosp.
- 25 Peoria General - St. Francis Medical Ctr.
- 26 Chicago Heights Cardiac - St. James Hosp.
- 26 Elgin - Sherman Hospital
- 27 Champaign Children's Home - Champaign
- 27 Exceptional Care & Training Ctr. - Sterling

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



Each capsule contains 5 mg chlorthalidone HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlorthalidone HCl and/or clidinium bromide

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librax® (chlorthalidone HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlorthalidone HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlorthalidone HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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ROCHE

# IN G.I. THERAPY

**For Irritable  
Bowel Syndrome\*  
and Peptic Ulcer\***

Librax...the only G.I. medication that provides the action of Librium® (chlordiazepoxide HCl) to relieve the accompanying anxiety found in some patients, plus the action of Quarzan® (clidinium bromide) to reduce colonic spasm and gastric hypersecretion.

Specify **Librax** Adjunctive

Each capsule contains 5 mg chlordiazepoxide HCl  
and 2.5 mg clidinium Br.

*Antianxiety/Antisecretory/Antispasmodic*

Librax has been evaluated as possibly effective for these indications.  
Please see summary of prescribing information on facing page.



# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**BENTON:** Family Physician wanted to join growing medical staff associated with a modern, 113-bed community hospital in southern Illinois. Guarantee and other benefits. Excellent recreational and university facilities nearby. CONTACT: Ann Acton, Franklin Hospital, Benton, 62812, (618) 439-3161, Ext. 367/368. (4)

**CARBONDALE:** Family or General Practice. Community Health Center in southern Illinois, 10 miles from SIU-Carbondale. Affiliation with Black Lung Clinic Programs possible. Established practice with multi-disciplinary staff. Position available immediately. Salary, fringe benefits are very competitive; malpractice insurance and vacation also provided. CONTACT: George M. O'Neill, Shawnee Health Service & Development Corporation, 103 S. Washington, #210, Carbondale 62901 (618-457-3351). (4)

**CENTRAL ILLINOIS:** Two community hospitals within twenty minutes of each other are currently seeking a urologist. Possible partnership with consulting urologist now servicing this area. More patients than one urologist can handle. Area is known for recreational activities. Contact: Search Committee, P.O. Box 430, Pana, 62557. (217-562-2131 x271) (4)

**CLIFTON:** Service Area, 8,500—Immediate opening for family practitioner in rural setting. First year: guarantee, office space/staffing provided. Seventy miles south of Chicago on interstate highway. Excellent school system. Obstetrics or general internal medicine background helpful. CONTACT: George Rasmussen, Central Community Hospital, Clifton 60927. AC 815-694-2392. (10)

**FAIRBURY:** Family practice physician—Excellent opportunity to join General Practice Physician planning retirement in two years. Cross coverage is available in this thriving rural practice. Fairbury Hospital, a 112-bed JCAH accredited hospital, offers income guarantees and other financial assistance. Contact: Kate H. Dickey, Director, Physician Recruitment, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739. (815-692-2346 x215) (4)

**GALESBURG:** Population 35,305. Seat of Knox County, pop. 61,300. An attractive college community 180 miles from Chicago. Near Peoria, Quad-Cities. Diversified industry and agri-

business. Full selection of educational, cultural and recreational activities. For information on practice opportunities, CONTACT: David D. Fleming, Vice-President, Galesburg Cottage Hospital, 695 N. Kellogg St., Galesburg 61401. 309/343-8131. (4)

**KEWANEE:** 108 bed community hospital involved in an expansion program is interested in recruiting family practitioners to our service area of 35,000 population. Several practice opportunities exist in group or solo practices. The population centers in the service area range from 15,000 in population and less. Contact Harold L. Bischoff, Kewanee Public Hospital, 719 Elliott Street, Kewanee 61443 (309) 853-3361. (4)

**LINCOLN:** 20 miles from Southern Illinois University School of Medicine in Springfield and halfway between St. Louis and Chicago on I55. Need two family practice physicians for growing practice. Office facilities available with 10 man medical group. Contact Mary Richter, 311 Eighth, Lincoln 62656. (217/732-9681). (4)

**MARSHALL:** Population 4,000. County seat of Clark County. Rural community. Comparatively new medical center with available space for 4 doctors. Presently have 2 doctors. Facility fully equipped with lab, x-ray, therapy, emergency room, pharmacy. Located 17 miles from three major hospitals. Have excellent school system and recreational facilities. CONTACT: Donald B. Smitley, Admin., 410 N. 2nd St., P.O. Box 219, Marshall 62441, 217-826-2358. (4)

**SULLIVAN:** Population 5,000. New medical center with complete office and ancillary services available. Near universities and colleges. All recreational facilities nearby. CONTACT: Sandra Elder, 2 W. Adams, Sullivan 61951 (217) 728-8316 or (217) 728-4186. (4)

**WATSEKA:** Population service area 35,000. Opening for orthopedic surgeon. 23 physicians on staff at present. 85 miles from Chicago in rural area, 160 bed hospital. Within one hour drive of major universities. Very liberal financial package available first year. Contact Paul F. Wenz, 200 Fairman Street, Watseka 60970. (815) 432-5201. (4)

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# Guest Editorial

## Hemoclips

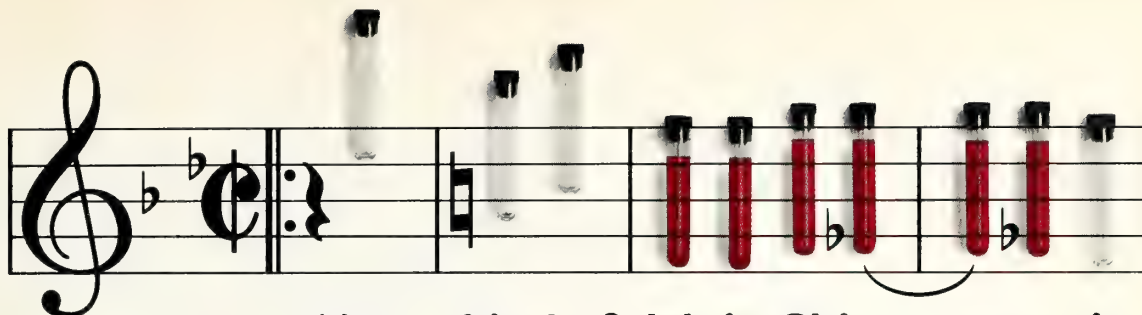
Complications in surgery are all too frequent and occur with reference to each of the techniques or procedures that we utilize. This month's case report by Raines, *et. al.*, entitled "Massive Hemobilia—A Complication of Hemoclips," again brings this thought to mind. The ease and facility that accompanies the use of hemoclips has been a distinct advantage to the surgeon and patient. Further, their time saving characteristics have led to their rapid spread throughout the surgical specialties. We see the post-thoracotomy or post-tubal patient's X-ray with the telltale metallic clip. These clips are utilized more and more for control of bleeders, closure of ducts, clipping of tubes, occlusion of small or large bronchi, tumor edge markers, holding of knots, etc.

There are problems that may occur, however, as illustrated by this month's article. The clips usually (an estimated 95 + %) do their job and do it well—even when used in circumstances where they were not originally designed to be used. This paper illustrates one of the problems that may occur—namely erosion into adjacent structures. With such an erosion, a communication then developed between an artery and a duct therefore producing a gastroduodenal artery-biliary duct fistula. The paper brings to mind that all newer modalities—though better in many ways—also have their unique complications. We have seen hemoclip applicators malfunction with resultant poor or crooked closure of the clip, hemoclips slip off the tissues, cystic duct remnants slough, the clip slip off the cystic duct, patients cough up the hemoclips,<sup>1</sup> or vessels bleed due to a cutting force. There are times when they will not apply correctly especially if more than one are used in the same area. Inadvertant clipping of adjacent tissues has been known to happen—especially in the depths of wounds. For example, ureters and nerves are known areas to observe. This article wisely brings to mind the potential complications of a widely used modality. With proper concern we should continue their usage.

Raymond A. Dieter, Jr., M.D.  
Member, *IMJ* Editorial Board

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Like clockwork, the fox's gray-brown fur turns completely white as the winter solstice approaches, and then returns to its normal color during the spring thaw. The fox's coat also undergoes a smoky blue phase. This cyclical camouflage enables the fox to blend readily with the changing scenery of its environment, masking it from predators and prey.

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**Contraindications:** Known hypersensitivity to drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety disorders and symptoms, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.*. *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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## "I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

May 3	Hinsdale Sanitarium & Hosp. & A.C.S.	Hinsdale
May 4	Chgo. Bd. of Health & Ill. Interagency Council on Smoking & Disease	Chicago
May 11	St. Francis Hosp. & A.C.S.	Blue Island
May 20	ACS Moderators' Training	Chicago
June 1	Chgo. Bd. of Health & Ill. Interagency Council on Smoking & Disease	Chicago
June 7	Hinsdale Sanitarium & Hosp. & A.C.S.	Hinsdale
June 14	Christ Hosp. & A.C.S.	Oak Lawn
June 16	A.C.S. Moderators' Training	Chicago
August 23	Christ Hospital & A.C.S.	Oak Lawn
Sept. 14	St. Francis Hosp. & A.C.S.	Blue Island


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Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents, and also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of child-bearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance,

namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

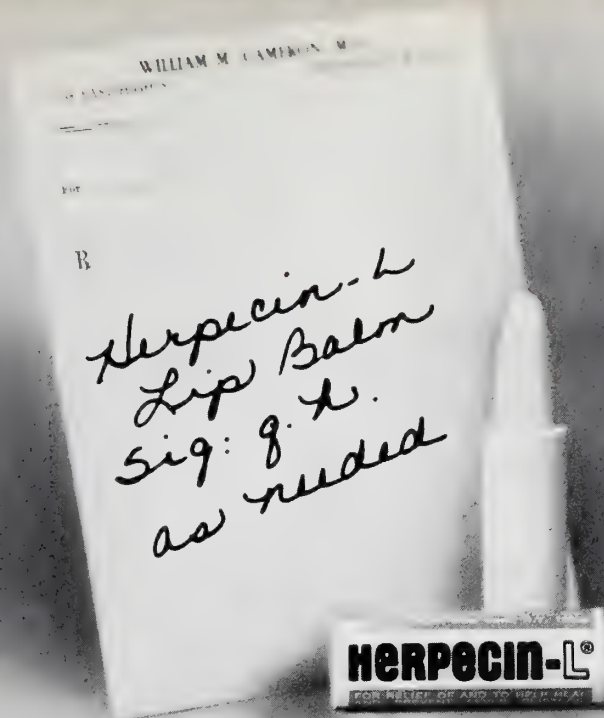
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## MALPRACTICE/LOSS PREVENTION EDUCATION

A Malpractice/Loss Prevention Education program will be held Friday and Saturday, May 21-22, at the Indian Lakes Resort, Bloomingdale, Illinois. This program, co-sponsored by ISMS, the Illinois Council on Continuing Medical Education and the Alexian Brothers' Medical Center, is designed to increase participants' understanding of the legal and professional implications of medical malpractice. Participants will learn ways to reduce the possibility of a malpractice suit through small group discussions and case studies outlining potential practice problems and solutions. General session topics include tort law, interpersonal communications and underwriting.

Registration begins at 3:30 on Friday. Fees of \$12.00 for ISMS members and \$25.00 for non-members will double for late registration after May 15. Checks should be made payable to the Illinois State Medical Society.

The program has been accredited for six hours of Category 1 CME credit, and registrants will be accepted on a first come/first served basis.

Further information may be obtained by writing Malpractice/Loss Prevention Education, Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, IL 60603.



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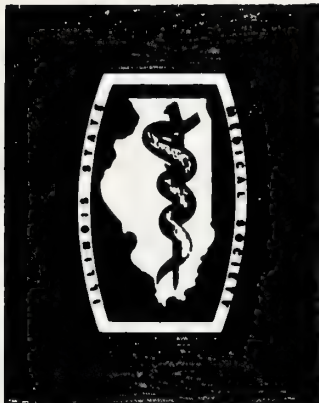
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# IMJ

*Illinois Medical Journal*

Volume 161, No. 4, April 1982

## *Laboratory Clues To The Diagnosis of Alcoholism*

### **M.I.L.T.**

BY WAYNE N. BURTON, M.D., F.A.C.P., AND LEE GLADSTONE, M.D./CHICAGO

*Biochemical and hematologic tests were performed on 93 alcoholic patients on admission. The tests were repeated on the tenth day of hospitalization.*

*"MILT" is an acronym representing a cluster of laboratory tests that we believe most useful for the primary care physician in identifying and treating the problem drinker.*

Alcoholism is a significant problem in an estimated 10% of the men and women seen by primary care physicians. Physicians are often hesitant to diagnose the patient as an alcoholic if the history and physical examination are ambiguous, as they frequently are. While an equivocal diagnosis often is accepted by the patient when diseases such as diabetes are involved, seldom is it accepted in the case of alcoholism, in which denial plays a powerful role. The goal of this paper is to suggest that certain screening blood chemistry and hematology tests can provide clues that make the diagnosis of alcoholism far more definitive. To assist the memory, we propose the acronym MILT to designate the following tests:

(1) **M = Mean Corpuscular Hemoglobin (MCV)  $\geq 100$**

and/or

**Macrocytic Changes on Blood Smear**

(2) **I = Serum Iron**

(3) **L = Liver Function Tests**

(4) **T = Triglycerides**

Taken together, these tests (1) increase the phy-

sician's index of suspicion of alcoholism, making alcoholism part of the differential diagnosis; (2) assist the physician in confronting the alcoholic patient and help overcome denial; and (3) eliminate the necessity for further diagnostic procedures in the alcoholic patient.

#### **Methods**

We studied 93 known alcoholic patients admitted to the Inpatient Alcoholism Treatment Program. These patients generally were drinking up until the time of admission. Patients with serious medical problems were admitted to general medical wards. The population had a mean age of 43.4 years (range: 22-74 years). Sixty-eight percent (68%) were males, 32% females. Fifty-nine percent were employed, 27% were on public aid, and 14% received Medicare or Medicaid.

Within 24 hours of admission all patients had a blood chemistry profile consisting of SMA-20 (alkaline phosphatase, SGOT, triglycerides, LDH, CPK, sodium, chloride, calcium, phosphorous, iron, glucose, total protein, albumin, creatinine, total bilirubin, cholesterol, BUN, uric acid, bi-



TABLE 1				
LABORATORY VALUES				
	Normal	Admission °	Day 10	P
M — Macrocytic smear and/or MCV ≥ 100		44%*		
I — Serum Iron	(40-170 ug %)	152 ± 81 ug %	107 ± 48	.0001
LDH	(0-250 mu/ml)	218 ± 76 mu/ml	185 ± 41	.0001
L — SGOT	(0-30 mu/ml)	66 ± 74 mu/ml	37 ± 39	.0001
Alkaline phos.	(30-85 mu/ml)	116 ± 77 mu/ml	89 ± 42	.0001
Total Bilirubin	(.0-1.3 mg %)	1.1 ± 1.3 mg %	0.7 ± 0.1	.001
T — Triglycerides	(50-150 mg %)	164 ± 136 mu	128 ± 66	.003
CPK	(0-200 mu/ml)	136 ± 181 mu/ml	70 ± 86	.002
Glucose	(65-110 mg %)	103 ± 74 mg %	85 ± 96	.023
Cholesterol	(120-270 mg %)	192 ± 49 mg %	188 ± 40	NS
BUN	(0-20 mg %)	13 ± 8 mg %	13 ± 4	NS
Creatinine	(.0-1.7 mg %)	1.1 ± 0.8 mg %	1.0 ± .2	NS
Uric Acid	(2.5-8.0 mg %)	6.9 ± 0.7 mg %	5.7 ± 1.3	NS
Sodium	(135-148 meq/L)	147 ± 4 meq/L	142 ± 3	NS
Potassium	(3.5-5.0 meq/L)	4.1 ± 0.7 meq/L	4.3 ± 0.5	.036
Chloride	(95-108 meq/L)	109 ± 9 meq/L	103 ± 3	NS
Bicarbonate	(24-32 meq/L)	28 ± 4 meq/L	28 ± 2	NS
Calcium	(8.5-10.5 mg %)	10.2 ± 0.8 mg %	9.3 ± 1.0	NS
Phosphorous	(2.5-5.0 mg %)	3.5 ± 0.6 mg %	3.7 ± 0.5	NS
Total Protein	(6.0-8.0 gm %)	7.0 ± 0.6 gm %	6.8 ± 0.6	.021
Albumin	(3.5-5.0 gm %)	4.0 ± 0.4 gm %	4.0 ± 0.3	NS
Hemoglobin	(14.0-18.0 gm %)	14.6 ± 4.2 gm %	13.9 ± 1.7	NS
Hematocrit	(40.0-54.0%)	41.2 ± 7.0%	40.7 ± 6.5	NS
WBC	(4.0-10.5x1000/mm)	7.2 ± 3.6x1000/mm	7.9 ± 4.4	.049
*Percent of patients				
°MEAN ± S.D.				

carbonate and potassium), hematology (WBC, RBC, HGB, HCT, Smear), chest X-ray (PA and lateral), resting standard twelve (12) lead electrocardiogram, and urinalysis.

Blood chemistries were repeated routinely on the tenth day of hospitalization, as well as other tests as clinically indicated.

## Results

**Hematology:** The admission mean hemoglobin, hematocrit, and white cell counts were 14.6gm%, 41.2% and 7,200, respectively. Forty-four percent of the population had an MCV ≥ 100 and/or macrocytic changes on blood smear. After ten days there was no significant change in mean hemoglobin or hematocrits, but there was a significant rise in the mean white blood cell count ( $p < .049$ ). The presence of macrocytosis, or an elevated MCV, is known to persist for weeks or even months of abstinence; therefore, although helpful in the identification of the alcoholic, it does not necessarily change after ten days.<sup>1</sup>

**Chemistry:** A blood chemistry survey was performed on all patients within 24 hours of admission and repeated on the tenth day of hospitalization. Mean serum iron fell significantly

( $p < .0001$ ), from 152 to 107mg%. Serum glucose fell significantly ( $p < .023$ ), from 103 to 85mg%. Serum cholesterol did not change (192mg% vs. 188mg%), although serum triglycerides fell significantly, from 164 to 128mg%.

All four liver function tests declined significantly, including LDH (218 vs. 185mu/ml), SGOT (66 vs. 37mu/ml), alkaline phosphatase (116 vs. 89mu/ml), and total bilirubin (1.1 vs. 0.74mg%). Total serum protein declined slightly from 7.0 to 6.8mg% ( $p < .021$ ), while serum albumin remained unchanged at 4.0gm%. Kidney function tests did not change, with the BUN (12.9 vs. 12.5mg%) and creatinine (1.1 vs. 1.0mg%) remaining stable. Similarly, the uric acid (6.9 vs. 5.7mg%), calcium (10.2 vs. 9.3mg%), and phosphorous (3.5 vs. 3.7mg%) did not significantly change. The CPK fell from 136 to 70 mu/ml ( $p < .002$ ). Electrolytes, including sodium, chloride and bicarbonate, did not change significantly. The serum potassium rose from 4.1 to 4.3meq% ( $p < .036$ ).

**Miscellaneous:** Chest X-ray, electrocardiogram and urinalysis were not helpful in the diagnosis of alcoholism.

## Discussion

Various laboratory tests have been advocated to aid the physician in diagnosis of the alcoholic patient. Direct testing of breath, blood, and urine for alcohol levels is useful under certain circumstances, but if the patient has been abstinent for a day before his visit to the physician, these tests will be negative for the presence of alcohol.

Biochemical and hematologic tests long have been recommended as screening tools for alcoholism. Several authors have advocated single liver tests such as the GGT (gamma glutamyl transferase), which, when elevated, are indicators of the liver dysfunction so common in alcoholics.<sup>2</sup> Shaw and his colleagues have suggested the ratio of alpha-amino-N-butyric acid to leucine.<sup>3</sup> The disadvantage of these and other tests is that they are not routinely performed as part of multiphasic blood profiles, may be expensive, and are not as specific for alcoholism as MILT.

A variety of multiphasic profiles have been identified, but they are complex and difficult to apply clinically. Jankowski and Drum recommend the cluster of seizures, hepatomegaly, MCV, SGOT, GGT, but rarely would all be present in a patient in the early stages of alcoholism.<sup>4</sup> Morse and Hurt suggest the GGT, SGOT, MCV, triglycerides, alkaline phosphatase, bilirubin, and urinalysis as helpful.<sup>5</sup> Ryback identifies various components of the SMA 6, SMA 12, and hematology in a large group of alcoholics, but does not emphasize how much more valuable they are when viewed as a cluster.<sup>6,7</sup> The National Council on Alcoholism's "Criteria for Diagnosis of Alcoholism" uses a track system—based on physical, psychological and social criteria—to rate a patient's probability of having an alcohol problem.<sup>8</sup> To date, it has not gained wide acceptance in clinical practice, perhaps because it is cumbersome and time-consuming.

We have studied comprehensive hematology and blood chemistry profiles on 93 inpatients in an alcoholism treatment program. These tests were performed on admission and on the tenth day of hospitalization. A cluster of tests which were markedly abnormal on admission and significantly improved by the tenth day (except for MCV, which remained abnormal) were assigned the acronym MILT.

Certain other tests, such as the CPK, WBC, glucose, and potassium, statistically improved significantly after ten days of abstinence. However, the elevation in CPK was usually the result of intramuscular medications administered to patients on admission and therefore is not an elevation generally present in outpatient alcoholics, and other laboratory abnormalities

achieved far less statistical significance than those present in MILT and were not included.

It is important to note that normal laboratory tests do not necessarily exclude the diagnosis of alcoholism.

## Diagnostic Criteria

The first component of MILT is an elevated MCV ( $\geq 100$ ) and/or macrocytic changes on blood smear, present on admission in 44% of our patients. The MCV is frequently elevated in chronic alcoholics and generally stays elevated for weeks or months, despite abstinence and good nutrition.

The second component of MILT is an elevated serum iron, found in 38% of the patients on admission. In all but 12%, the level had returned to normal on the tenth day of hospitalization. Serum iron is now routinely present on many multiphasic biochemical screening panels. Several studies have pointed out that alcohol may elevate the serum iron level, which does not return to normal until after cessation of alcohol consumption.<sup>9,10</sup> They propose three major theories for the etiology of the elevated serum iron in alcoholics: increased serum iron may be due to the high iron content of some alcoholic beverages, particularly wine; the elevated serum iron level may result from increased secretion of hydrochloric acid produced in the stomach by alcohol; alcohol inhibits a coenzyme, pyridoxal kinase, involved in iron utilization, resulting in a rise in serum iron levels.

Liver function tests long have been promoted as a laboratory clue to the diagnosis of alcoholism, although abnormal liver function tests usually reflect a late stage of alcoholism. The aminotransferases (SGPT, SGOT) are thought to be less sensitive but more specific than the gamma glutamyl transpeptidase (GGT). While the SGOT and GGT may fall rapidly with abstinence, the serum alkaline phosphatase falls more slowly and may be the last test to become normal. If all of these tests, in addition to the serum bilirubin, are elevated, more significant liver disease is indicated. Non-alcoholic liver disease should always be considered in the alcoholic patient with abnormal liver function tests, as noted by Levin and his colleagues, who suspected and confirmed such disease in 28% of their patients receiving biopsies.<sup>11</sup>

The final component of MILT, elevated serum triglycerides, was noted in 35% of patients on admission, although cholesterol levels were normal. Castelli and his colleagues report a strong correlation between alcohol consumption and blood lipids.<sup>12</sup>



The greater the number of MILT abnormalities present, the greater the suspicion that an alcohol problem is causing them. The laboratory tests may then be repeated, on an outpatient basis, after at least ten days of abstinence to substantiate the suspicion of alcoholism and demonstrate to the patient the importance of alcohol in the laboratory abnormalities. Recognition of the MILT cluster would alert the physician to wait for the repetition of the tests before undertaking further diagnostic evaluation. If the abnormalities have not been resolved after ten days, further evaluation certainly would be indicated.

The laboratory clues—the MCV, serum iron, liver function tests, and triglycerides—represented by the acronym MILT, will assist the physician in the identification and confrontation of the alcoholic patient. ◀

### Acknowledgment

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**WAYNE N. BURTON, M.D., F.A.C.P.,** is a board certified internist affiliated with the Northwestern University Medical School and Northwestern Memorial Hospital in Chicago. An assistant professor of clinical medicine at Northwestern University Medical School, Dr.

Burton is a fellow of the American College of Physicians.



**LEE GLADSTONE, M.D.,** is an assistant professor of psychiatry, Northwestern University Medical School, and on the staff of Northwestern Memorial Hospital in Chicago. Dr. Gladstone is closely associated with the Northwestern Memorial Hospital Institute of Psychiatry, where he serves as co-chief of the Chemical Dependence Program and special assistant to the director. He is a member

of the Illinois State Medical Society Committee on Alcoholism and Drug Dependence, and the chairman of the ISMS Panel for the Impaired Physician.

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## A Clinical Review With Three Case Reports

# Fisher's Syndrome

PHILIP B. GORELICK, M.D., JOSE BILLER, M.D.,  
AND JOEL BRUMLIK M.D., PH.D./MAYWOOD AND HINES

*Three cases of acute neuropathy characterized by ophthalmoplegia, ataxia, and areflexia are reviewed. The clinical course, cerebrospinal fluid findings and electromyographic studies suggest a close relationship to the Guillain-Barré Syndrome.*

In 1956, Miller Fisher<sup>1</sup> reported three cases characterized by acute onset of external ophthalmoplegia, severe ataxia, and loss or diminution of deep tendon reflexes. Although the initial clinical picture was alarming in each case, vascular or neoplastic disease was not uncovered. The disease course was usually benign, and relatively complete recovery was the rule. The association of peripheral neuropathy with a rising cerebrospinal fluid (CSF) protein and a low cell count (albuminocytologic dissociation) suggested a close relationship to the Guillain-Barré syndrome. This communication will describe three cases and review clinical features.

### Case 1

A 61-year-old white female presented to the emergency ward with a one day history of double vision and unsteady gait. Ten days prior to the admission she had had an upper respiratory infection. Family and past medical histories were unremarkable.

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**Joel Brumlik, M.D., Ph.D.,** is a board certified neurologist affiliated with the Loyola University Stritch School of Medicine, Maywood. Professor and chairman for the Loyola department of neurology, Dr. Brumlik is a member of the medical advisory board for both the Myasthenia Gravis Foundation as well as the Multiple Sclerosis Society of Chicago.

**Jose Biller, M.D.,** is an assistant professor of neurology at the Loyola University Stritch School of Medicine, Maywood. At this writing, he was also a cerebrovascular neurology fellow at the Bowman Gray School of Medicine, Wake Forest University, Winston-Salem, North Carolina.

**Philip D. Gorelick, M.D.,** is a neurologist who recently completed his residency training at the Loyola University-Stritch School of Medicine and Hines Veterans Administration Hospital.

Physical examination revealed moderate bilateral ptosis with complete inability to move the eyes in any direction upon command, following a target, or with changes in head position. The optokinetic responses were absent near reflexes. The pupils were round and reacted sluggishly to light and object proximity. Ophthalmoscopy, visual fields, and acuity were normal. Deep tendon reflexes were absent. The plantar responses were flexor bilaterally. Her gait was wide-based, and ataxia was noted on finger-to-nose and heel-to-shin testing. The remainder of the neurological and general physical examination was unremarkable. Routine admission laboratory values and chest roentgenogram were normal.

Administration of edrophonium chloride did not alter the ocular findings. CSF analysis on the seventh day of illness was unremarkable. Electromyogram (EMG) and Nerve Stimulation Studies (NSS) revealed F-wave slowing and a prolonged facial nerve latency consistent with a diffuse polyradiculopathy.

### Case 2

A 62-year-old male complained of double vision and gait unsteadiness of one week's duration. He also noted hand tingling. Fourteen days prior to admission he had experienced an upper respiratory illness. Past medical, social, and occupational histories were unremarkable.

On examination, the eye movements were severely restricted in all directions and moderate ptosis was noted. Pupil responses to light and object proximity were impaired. His gag reflex was diminished, and his speech had a nasal quality. He had generalized areflexia and impairment of position sense in the lower extremities with preservation of other sensory modalities. Motor examination showed slight weakness of the right



<div>Table 1</div> <div>Summary of Cases</div>							
Case Number	Age/ Sex	Preceding Event	Period of Development (Days)*	Presenting Complaint	Neurological Findings	CSF (hospital day)	EMG/NSS
1	61/F	Upper respiratory infection	10	Diplopia and gait ataxia	Complete internal and external ophthalmoplegia. Bilateral ptosis. Areflexia. Limb and gait ataxia.	Normal (7th)	Diffuse polyradiculopathy
2	62/M	Upper respiratory infection	14	Diplopia and gait ataxia	Incomplete external ophthalmoplegia. Bilateral Ptosis. Impaired pupillary responses. Diminished gag reflex. Nasal speech. Impaired proprioception in lower extremities. Areflexia. Upper limb dysmetria. Mild weakness (right side).	95mg/dl protein, 4 cells (1st week)	Not performed
3	58/M	Upper respiratory infection	9	Diplopia and gait ataxia	Incomplete external ophthalmoplegia. Right ptosis. Areflexia. Limb and gait ataxia. Generalized weakness.	52mg/dl protein, no cells (3rd)  176mg/dl protein, 1 cell (16th)	Diffuse polyneuropathy
*Interval in days between preceding event and onset of neurological symptoms							

limbs. Bilateral finger-to-nose dysmetria was present. General physical examination was unremarkable. Routine blood chemistries and urinalysis were normal. The CSF was clear and colorless with four lymphocytes per cubic millimeter and a protein content of 95mg/dl.

### Case 3

A 58-year-old male awoke with double vision and unsteady gait. In addition, he noted numbness of the hands and feet. Nine days prior to admission he had had an upper respiratory infection.

Initial neurological findings revealed gait and limb ataxia, subjective diplopia, and absence of deep tendon reflexes. Motor and sensory examination failed to show an abnormality. The fundi and visual fields were normal. On the seventh hospital day, he was noted to have bilateral limitation of ocular movements in all directions and a moderate right-sided ptosis. The strength in the upper extremities had now diminished. No other abnormalities were noted on neurological examination.

Routine admission laboratory values were normal. A CSF examination on the third hospital day showed no cells and a protein content of 52mg/dl. A repeat study on the sixteenth hospital

day revealed one lymphocyte per cubic millimeter and a protein level of 176mg/dl. EMG and NSS revealed slowing of the nerve conduction velocities in the upper and lower extremities which were compatible with an early demyelinating neuropathy and/or radiculopathy.

### Discussion

The clinical features of the three cases are summarized in Table 1. The Guillain-Barré syndrome is characterized by symmetrical, ascending paralysis, sometimes associated with cranial nerve dysfunction that can lead to respiratory insufficiency. The criteria required for a proper diagnosis have been published.<sup>2</sup> The variant described by Miller Fisher in 1956 was thought to be related to the Guillain-Barré syndrome in view of the clinical similarities and the occasionally elevated CSF protein. Fisher concluded that the clinical triad of ataxia, ophthalmoplegia and areflexia was a variant of the syndrome of acute idiopathic polyradiculoneuritis. Review of the literature reveals that this variant has been reported from the ages of five to 85 years, although it is more common in the adult population.<sup>3-9</sup> Men are affected more often than women.

A history of a preceding upper respiratory af-

flection is often noted. The majority of patients are afebrile during the onset of neurological symptoms. The interval between prior illness and the onset of neurological complaints ranges from days to weeks with an average of 16 days.<sup>5</sup> A presenting complaint of double vision is very common, while unsteadiness of gait and migratory paresthesias may also occur. The triad of ophthalmoplegia, ataxia, and areflexia are the physical hallmarks of this disorder. The combination of complete external ophthalmoplegia and internal ophthalmoplegia is rare. Other cranial nerves that can be involved are V, VII, IX, X, XI and XII. Objective sensory signs may include decreased vibration, proprioception, pin, and touch sensations. Varying degrees of motor weakness have also been reported.

A valuable laboratory aid for establishing the diagnosis is elevated protein content in the CSF after the first week of symptoms or a rise in protein on serial lumbar punctures. CSF cell counts of 10 or fewer mononuclear leucocytes are expected. During the first ten days NSS may be normal; slowing develops as demyelination proceeds. If only the proximal portion of the nerve is affected, NCV study may be normal, and only

the F-waves then show slowing. The latter, then, is as important to the interpretation of the EMG as the point at which the study is performed. ◀

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# Case Reports

## A Complication of Hemoclips

### Massive Hemobilia

BY LAWRENCE A. RAINES, M.D., NORMAN L. WOOL, M.D. AND  
STEVEN G. ECONOMOU, M.D./CHICAGO

*Aneurysms of the gastroduodenal and pancreaticoduodenal arteries are uncommon and usually asymptomatic. However, complications of these aneurysms have been reported.<sup>1-5</sup> A case of massive hemobilia secondary to gastroduodenal artery aneurysm-choledochal fistula is presented. The fistulous communication between the aneurysm and the common duct was caused by a hemoclip. Preoperative angiography accurately localized the communication, facilitating prompt control of the hemorrhage by selective ligation of the gastroduodenal artery.*

The patient was a 71-year-old white male who had had a cholecystostomy six years previously. This limited operation had been thought appropriate because of an intensely scarred and inflamed gallbladder. He felt well for five years, but then began a year of intermittent chills, fever, and jaundice, after which he had an exploratory celiotomy with cholecystectomy and common duct exploration. This resulted in the finding

of a 2.5cm. x 5cm. stone and associated "gravel" in a common duct approximately 2cm. in diameter. An intraoperative cholangiogram following the exploration was thought to be normal. Eleven days postoperatively, the patient bled through a T-tube. A T-tube cholangiogram on the following day demonstrated a common duct 1.6cm. in diameter which contained a 4cm. x 1cm. smooth filling defect believed to be

blood clot (Figure 1). Angiograms were performed and showed a gastroduodenal artery aneurysm communicating with the common duct (Figure 2). He was transfused three units of whole blood, begun on parenteral cefazolin and chloramphenicol, and then transferred for further therapy.

On admission, the patient was clinically markedly icteric. Temperature was 100.4°F. orally, blood pressure 130mm.Hg. systolic, 64mm.Hg. diastolic, and the pulse 104 per minute. The abdomen was soft and without organomegaly or masses. A T-tube was in place and was not draining blood or bile. Tenderness was present over the right upper quadrant of the abdomen; this was thought the result of recent surgery. The remainder of the physical examination was unremarkable.

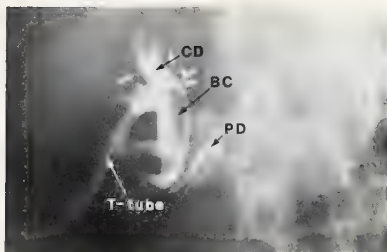
Laboratory findings were as follows: Hb 11.3mg.%, WBC 27.2mm.<sup>3</sup> with a left shift, normal platelet count, total bilirubin 13.3mg.%, SGOT 109 IU/L (N 5-35), SGPT 140 IU/L (N 5-30), LDH 280 IU/L (N 90-220), CPK 92 IU/L (N 25-145), alkaline phosphatase 275 IU/

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**LAWRENCE A. RAINES, M.D.**, is a resident in general surgery and instructor in surgery affiliated with Rush-Presbyterian-St. Luke's Medical Center and Rush Medical college in Chicago.

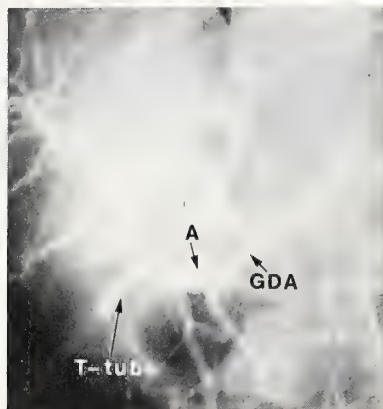
**NORMAN L. WOOL, M.D.**, is a board certified general surgeon and instructor in surgery affiliated with Rush Medical College and Rush-Presbyterian-St. Luke's Medical Center in Chicago. The assistant director of undergraduate medical education at Rush, Dr. Wool was the recipient of the Rush General Surgery Senior Resident Award for 1980.

**STEVEN G. ECONOMOU, M.D.**, is a board certified surgeon and Jack Fraser Smith Professor of Surgery at Rush Medical College and Rush-Presbyterian-St. Luke's Medical Center in Chicago. The associate chairman, Department of Central Surgery at Rush, Dr. Economou is also a clinical professor of surgery at the University of Illinois College of Medicine, Chicago. At Rush, Dr. Economou has served as chairman of the Tumor Committee, co-director of the Tumor Clinic and director, Laboratory of Surgical Research. He is a member of the Illinois Cooperative Oncology Network, and an active member of the American College of Surgeons and American Cancer Society.



**Figure 1**

T-tube cholangiogram demonstrates dilated common bile duct (CD) with large lucent filling defect caused by blood clot (BC). The pancreatic duct (PD) is also seen.



**Figure 2**

Preoperative angiogram demonstrates gastroduodenal artery (GDA) aneurysm (A).

L ( $N < 100$ ),  $Ca^{++}$  8.5mg.% ( $N$  8.7-10.7), and a normal coagulation profile.

The angiograms were reviewed with a view toward percutaneous selective balloon occlusion or embolization of the gastroduodenal artery similar to what has been previously reported for other vessels.<sup>2,7-9</sup> It was felt, however, that successful embolization was not possible anatomically and that balloon occlusion was not feasible technically. There was no evidence of active bleeding and the patient was simply observed.

The following day, he had a shaking chill, passed approximately one liter melanic diarrheal stool and became hypotensive. He stabilized following a transfusion of two units of packed red blood cells and was taken to the operating room where the previous right paramedian incision was used for abdominal reentry. Using the T-tube as a guide, the common duct was identified and opened, at which point bleeding was seen to be taking place within the duct. The T-tube and a blood clot which had formed into a cast of the extra-hepatic bile duct were removed at which point a hemoclip was seen posteriorly within the lumen of the common duct. About three-fourths of the hemoclip was protruding into the common duct with steady bleeding in its vicinity. With removal of the clip, a partially clotted aneurysmal-choledochal communication was now larger and the bleeding became very brisk and clearly arterial in character. It was possible to con-

trol the bleeding by digital pressure over the opening as the gastroduodenal artery cephalad to the duodenum was dissected and a suture ligature placed near its origin from the common hepatic artery. The bleeding immediately stopped. With the bleeding controlled, the common duct was explored. Five stones were found, the largest 1.3cm. in greatest dimension. A T-tube was placed in the common bile duct and the incision closed in a routine manner. During his postoperative convalescence, the abnormalities in liver function returned to normal. A T-tube cholangiogram also was normal.

## Discussion

Although hemoclips are used very commonly and generally are considered safe, this case serves to remind surgeons to use caution when placing them near vital structures. There is at least one other report describing erosion of a hemoclip into the common duct.<sup>6</sup> Other reports of complications of hemoclips cannot be found.

This case demonstrates very graphically the benefit of preoperative angiography in localizing the point of bleeding in hemobilia. As has been described previously, aneurysm of the hepatic artery is ten times more frequent as a cause of hemobilia than aneurysm of the gastroduodenal artery.<sup>4</sup> At the time of

operation, it would have been difficult to identify the arterial source of bleeding because of the extensive adhesions and fibrosis resulting from the previous operation. This foreknowledge made it necessary to simply identify and ligate the gastroduodenal artery for effective control of the bleeding.

## Summary

A case of massive hemobilia secondary to gastroduodenal artery aneurysm-choledochal fistula is presented. The fistulous communication between the aneurysm and the common duct was caused by a hemoclip. Preoperative angiography accurately localized the communication, facilitating prompt control of the hemorrhage by selective ligation of the gastroduodenal artery. ◀

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# Case Reports

## Euthyroid Cretinism In An Adult With An Ectopic Thyroid

BY ROBERT W. KIRBY, M.D. AND THEODORE A. KOTCHEN, M.D./  
URBANA AND LEXINGTON, KENTUCKY

*An untreated adult with ectopic thyroid tissue and stigmata of congenital hypothyroidism was evaluated. Her case history illustrates the natural history of this form of cretinism.*

The natural history of untreated sporadic cretinism associated with ectopic thyroid tissue is seldom observed. Patients are usually diag-

nosed in neonatal or early childhood life when symptoms and signs of hypometabolism accompany mental retardation and delayed physical de-

velopment.<sup>1</sup> Unlike untreated patients with goitrous hypothyroidism due to defects in hormongogenesis, hypothyroid patients with ectopic glands rarely develop sufficient hyperplasia of thyroid tissue to result in goiter<sup>1</sup> and euthyroidism is achieved only with chronic thyroid hormone therapy. An untreated euthyroid adult with ectopic thyroid tissue and stigmata of congenital hypothyroidism was recently evaluated.

The history was obtained from a sister who related that the patient was born in Eastern Kentucky in 1922. Details of birth, neonatal life, and childhood development are unknown. The patient was always mentally slow and of short stature for age but grew slowly to at least age 16. She was said as a child to have had an "open skull." Though an amiable, well behaved child, she never attended school. Menarche occurred at age 25 and menstrual interval was regular until she devel-



**THEODORE A. KOTCHEN, M.D.**, is a professor of medicine and chief of the Division of Endocrinology-Metabolism, at the University of Kentucky School of Medicine in Lexington. A diplomate of the American Board of Internal Medicine with subspecialty of endocrinology, Dr. Kotchen is a fellow of the American College of Physicians and a highly active member of the American Heart Association.



**ROBERT W. KIRBY, M.D.**, is a board certified internist and endocrinologist affiliated with the Carle Clinic Foundation and University of Illinois College of Medicine, Urbana. A fellow of the American College of Physicians, Dr. Kirby serves as head of the Department of Endocrinology Metabolism at Carle and clinical associate professor of medicine for the university.



oped amenorrhea at age 49. When the patient was 40 years old hypothyroidism was diagnosed and thyroid extract was taken for about two years. She delivered a healthy male infant by cesarean section six years later. During pregnancy an anterior neck mass was first noted which subsequently enlarged slowly but progressively. There was no history of cold intolerance or constipation. The patient's hair had always been thin and coarse. She was able to assist with minor household chores and to converse in short phrases. Four sisters and two brothers were well as was the patient's son. No thyroid disease was known in other family members.

### Examination

Physical examination revealed a quiet woman who responded hesitantly to questions with nodding of her head or short phrases. Blood pressure was 100/60mmHg and pulse rate was 80 beats per minute. Symphysis to heel height was 53cm and symphysis to vertex height was 61cm. Head circumference was 56cm and waist 76cm. Weight was 34kilograms. The skull was depressed in the area of the anterior fontanelle. Scalp hair was thin and coarse (Figure 1). She had bilateral senile cataracts, periorbital puffiness and blepharoptosis. She was endentulous with a normal appearing tongue. An anterior midline cervical

mass measuring 5.5cm in maximal diameter was located just above the hyoid bone and had the consistency of thyroid tissue. The abdomen was protuberant with diastasis recti present. Axillary hair was absent and pubic hair scant. Skin was dry and thickened. Digits were short and stubby in appearance and hyperextensible. Deep tendon reflexes were normal, as was her gait.

Laboratory evaluation revealed a normal complete blood count and urinalysis. Serum studies revealed a total thyroxine concentration by competitive protein binding of 7.8mcg/dl, triiodothyroine resin uptake of 28%, thyroid stimulating hormone concentration of 5.2uU/ml, and total cholesterol concentration of 265mg/dl. Serum follicle stimulating hormone concentration was 239uU/ml and luteinizing hormone concentration was 76uU/ml. Serum human growth hormone concentration rose from 6.1ng/ml before to 21.4ng/ml 60 minutes after intravenous infusion of 15gm of arginine hydrochloride. Lymphocyte karyotype was 46XX.

Roentgen studies revealed an adult bone age, flattened femoral heads, open anterior fontanelle, symmetrically enlarged sella turcica, and absent pneumatization of the mastoids. Cardiomegaly was present. Electrocardiogram revealed left ventricular hypertrophy.

Radionuclide scan with I-131 revealed symmetric uptake only in the region of the palpable neck mass. Twenty-four hour I-131 uptake was 12% of the administered dose and rose to 20.5% 24-hours after the intramuscular administration of 10 units of bovine thyroid stimulating hormone (TSH). No change in the pattern of the I-131 uptake occurred on scanning after TSH. Ten days after the administration of 3.0 mg of L-thyroxine orally, the 24 hour I-131 uptake was 1%.

### Literature Review

Cretinism has been defined as "permanent retardation in development of the skeleton or central nervous system resulting from thyroid deficiency which existed during fetal or early neonatal life."<sup>2</sup> The pa-

tient's short stature associated with juvenile body height proportions and mental retardation are characteristic developmental abnormalities of patients who are thyroprivic in early life. Further evidence of neonatal or juvenile hypothyroidism was provided by osseous abnormalities typical of adult cretinism, including enlarged sella turcica, absent pneumatization of the mastoids and open cranial sutures.<sup>3</sup> At the time of her evaluation, however, the patient was euthyroid and radioactive I-131 uptake, although ectopically located, responded normally to TSH suppression and stimulation.

Isolated ectopic thyroid tissue is commonly associated with sporadic cretinism. The hypothyroidism is attributed to limited secretory reserve of the ectopic tissue which is inadequate to keep pace with the needs of the growing infant.<sup>4</sup> Mental retardation is thus less severe in cretins with ectopic thyroid tissue than in anthyrotic cretins who presumably do not have benefit of even marginal thyroid function.<sup>1</sup>

Unlike goitrous hypothyroidism due to defects in hormongogenesis, patients with ectopic tissue seldom have palpable thyroid tissue in childhood<sup>1</sup> and spontaneous euthyroidism through TSH mediated functional hypertrophy has not been observed. The long-term observations in this patient suggest that ectopic thyroid tissue insufficient to support normal development in neonatal life may, after many years of chronic TSH stimulation, undergo hypertrophy sufficient to result in euthyroidism in adulthood. ◀

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1. Promoting Health/Preventing Disease: Objectives for the Nation. U.S. Department of Health and Human Services, November 1980  
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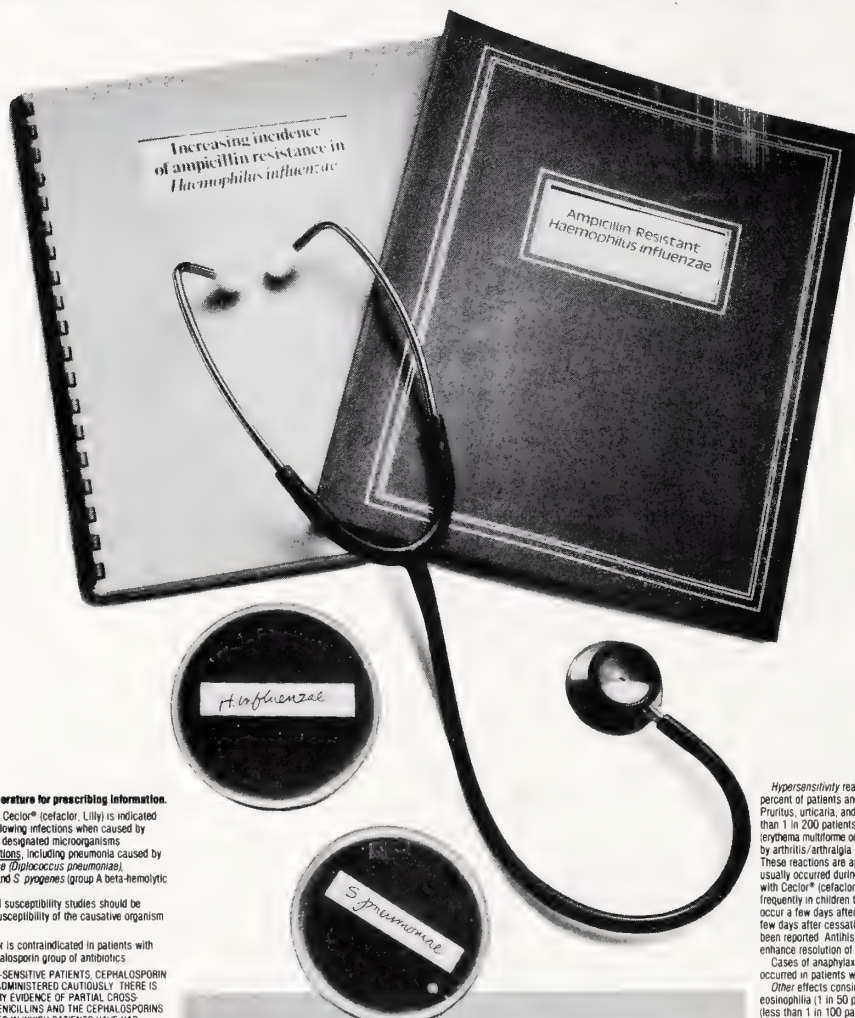
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# An added complication... in the treatment of bacterial bronchitis\*



## Brief Summary.

Consult the package literature for prescribing information.

**Indications and Usage:** Cefaclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

**Lower respiratory infections,** including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

**Contraindication:** Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

**Usage in Pregnancy—**Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

**Usage in Infancy—**Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

**Gastrointestinal symptoms** occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefaclor.

## Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Cefaclor.<sup>1-6</sup>

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.<sup>7</sup>

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefaclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship Uncertain—**Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Hepatic—**Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Hematopoietic—**Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

**Renal—**Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(1007291R)

\*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

**Note:** Cefaclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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# In Pursuit of the Greater Good

*Fred Z. White, M.D., Chillicothe, left the office of ISMS President on April 18. We asked Dr. White to share his perspective on ISMS and the experiences of the past year. This article is excerpted from that interview.*

**IMJ:** *When you were inducted as president, Dr. White, you talked about seeking a greater good and concentrating on the good of the whole over that of special interest groups. Through the year, you've addressed various special interest groups and how they impact on decisions, legislatively and administratively. I'd like you to tell me about the greater good concept, and how we can keep that perspective.*

**Dr. White:** Let me do that in layers. All physicians are fragmented individuals. They wear many hats. You belong to your hospital staff, your specialty society, your state medical society, and to many other organizations and groups. There are all of those fragmentations within medicine. What I meant, in terms of the greater good, was that the hospital staff may have a particular special interest that may be quite different from that of the rest of medicine. The specialty society may have a special interest in their area of expertise, but there's also a general interest in medicine, in the profession. In the realm of physicians in their medical activities, I was referring to the greater good of the profession.

**IMJ:** *And beyond that context?*

**Dr. White:** If we consider the profession as an entity with a specific

body of knowledge that has certain responsibilities, what makes it different from a trade union? Plumbers also have a specific body of knowledge that they have to gain before they become plumbers and that they have to maintain and update as they go along. Physicians have the same system. It's important, I think, for each group to train its own. Plumbers do that with apprenticeships. We do it with medical school, graduate education and continuing education. Again, no difference.

The big difference, it seems to me, is that the thrust of a profession is not to protect itself. That's the thrust of a trade union—it's self protective. The thrust of a profession is to protect the public, to ensure that service to the public is adequate and of a high caliber. That's what I meant by the greater good: a more universal spirit. Our purpose is to assure that the quality of care that we give the public is good.

**IMJ:** *Then the profession determines the quality of service provided. How?*

**Dr. White:** One example is public aid negotiation. We can say that we need more money. That's one way and that would be crass and that would be the union approach, if I can use that term. The other way would be to say that we want to assure that public aid recipients have access to the system. We want to

make sure that the quality of the care they receive is good, and that costs money. It might cost more money at the onset, but it might be more cost effective to assure that people have primary care and get into the system. The motto over the door is to assure that the service the public receives is superior.

**IMJ:** *You've dealt several times with what might be the biggest philosophical issue: who will ultimately carry the burden of making difficult kinds of decisions? That is, where will care be limited, where will the dollars be stopped, who will get that heart-lung machine? Or, when will society be brought to understand that the physician's responsibility is to present the alternatives, and to respect the patients' needs. If these questions fall to society as a whole, where do you think we'll be in another 10 years?*

**Dr. White:** To best answer that question, I think we need a national perspective. For example, right now there are OSHA standards, which are to assure occupational safety and health. Standards to prevent cancer from arsenic poisoning cost about \$20 million per death averted, probably an unreasonable cost. For asbestos, that's about \$90,000 or \$100,000 per death averted, perhaps a reasonable cost. That's one branch of government that says we're willing to spend this amount of money to



prevent a death.

On the other hand, another branch of government is arguing about whether public health should pay for immunizations or not. It seems to me that at some point, we have to look critically at the whole safety/

sibility by being busy with what we're doing, and I think that just in the last few years physicians have become aware of the fact that we have to be part of the decision making process, in planning, in utilization review and, I hope, in setting na-

"hey, that's going to cost a lot of money. Do you really want to spend your money there or would you rather spend it somewhere else?"

I think, for example, with the Medicare, elder care, debate, what the AMA did was to say, "don't do that," and try to offer an alternative. It might have been better to say, "we understand that there's a need for some sort of a social support in health. The costs are going to be — —" At that time the information wasn't available, but it is now, so we should be involved in those discussions. If we're involved in the discussions, if we're involved in the decision making and the policy setting, and it comes out badly, then we can't complain. We had a shot at it. But if we abdicate our responsibility and don't try to get involved, I'll complain. If we go ahead and do it and make bad decisions on the basis of what information we have, we can't complain.

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***"The thrust of a profession is to protect the public, to ensure that service to the public is adequate and of a high caliber. That's what I meant by the greater good: a more universal spirit."***

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health/prevention issue and decide where our priorities lie. Typically, what we've done in society and in medicine, is work with terminal disease. In heart, for example, the first thing that came along was correction of rheumatic heart disease, constrictive valves, or valve replacement. It was much later that we learned that you can do a lot more with throat cultures to prevent strep infection. A more recent example is the amount of coronary bypass surgery. If people didn't smoke, there wouldn't be a need for that. We have to get our emphasis—nationally, societally, as well as medically—where it will do the most good. It might be a lot more cost effective to discourage people from smoking. It would probably save the need for coronary bypass surgery at some later date.

What I'm saying is that the emotional appeal is always to the end-point. It's very hard to drum up emotional appeal or professional concern about lifestyle changes. It's a lot easier for Jerry Lewis to come on television with his kids and draw all kinds of money on the emotional aspect. I'm not being critical of that. But what I think I can be critical of is that physicians haven't really been involved. We abdicated our respon-

sibility. That's where coalitions and other things may become relevant.

**IMJ:** *What are some areas where medicine hasn't—but should—have input?*

**Dr. White:** We haven't been involved in benefit package planning, when management and labor sit down and devise a health package. The physicians are given that pack-

**IMJ:** *You have touched upon the idea of a new coalition of business and industry and government to handle U.R. and health planning. What exactly is this coalition? Has there been an invitation to join these groups, or how are they to be formed? How do they relate to government agencies' phasing out?*

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***"My further concern is that if we aren't involved . . . the only constraint . . . will be dollars. They won't look at the human part of it."***

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age to deal with and the complaint is that we're spending too much money. That's burlesquing a little bit, but that's what's happened. I would rather see us at that bargaining table, so that when union and management start to argue about what benefits can be included, we can say,

**Dr. White:** Let me separate planning from utilization review. Planning should be at the front end, if you will, looking to what resources we have, where we want to go, or how we get there. The HSAs, under public law 93-641, did that in a negative sort of way. They said, "Bring

us your plan and we'll tell you whether you can do it or not." It was not really on a regional basis because the hospitals all had their own plans, known to them only, and they brought forth what they wanted to. The only way the HSA could deal with that was to say, "yes, that's the right direction. You can go ahead." Or, "no, it's not the right direction. You can't go ahead."

But, it wasn't really planning, it was kind of gatekeeping, or negative regulation, that obviously didn't work. It became politicized and a whole lot of other things, and it just didn't work. There's a need for health planning. I think anybody would agree with that. It has to be done.

When there was a lot of money and there were no constraints, anybody could do their own thing, and that's what happened. What then occurred, was that people began to realize that the money was running out. The health planning law indirectly grew out of that need, and, as I said, didn't work. Failing that, then the people who are buying the health care, the state, the federal government, the private purchasers, and most of the carriers, the businesses with health benefits employment plans all know they're spending a lot of money and they can't afford to be non-profit. They're really concerned, and have begun to meet, either as businessmen buying the care and seeking to lower the cost or as trustees at various hospitals, looking at each other to see who can do what best. My concern with that is that if physicians aren't included, we'll be in the same position as we are with labor and business.

My further concern is that if we aren't involved in that, the only constraint, particularly with for-profit business purchasers of care, will be dollars. They won't look at the human part of it. They'll just be looking at the fiscal constraints. So, for those two reasons we must be in there to help them with the forward planning, as to what can be done and what shouldn't be done, and also to make sure that the human values are there



and that it's not all a bookkeeping, accounting process.

I think the best way to get involved is locally. Around the state these coalitions are beginning, in different forms. I don't think that we, as a state medical society, should impact on what form they take. I think our thrust should be to encourage, set the attitude, help physicians become a part, and then whatever comes out

of the local planning process, comes out of the local planning process. We can act as a resource. That's the front end. That's planning.

**IMJ:** *OK. Then the other end is U.R.*

**Dr. White:** At the other end, there has to be a ceiling to make sure that



utilization is appropriate, and most physicians are good utilizers. They do things in a thoughtful, cost effective way. But we need to be reminded. We need to have somebody reviewing us. Probably the best thing that came out of all of the review programs was the fact that review occurred. As we realized that we were going to be looked at, we got better. The analogy is that every morning when I wake up, I'm sure that I'm at least 6'2" with curly blond hair, steely blue eyes, and then I look in the mirror. I realize as I shave that it ain't all true.

The same thing is true with physicians in practice. You practice along and you're sure you're doing a good job, and you are. But you have no comparison. You don't know how you compare to your peers. And very often we get used to doing things the way we do because we do them that way. It's helpful,

**IMJ:** *That touches upon the discipline area, professional discipline and organized medicine. What about discipline at the local level? What do you think the responsible physician should be doing, professionally, in monitoring his peers when necessary?*

**Dr. White:** I think, again, we are doing it. We should take part in all of the different kinds of peer review activities. And they take place, not just in utilization review, but in continued education and all of the things that allow us to look at what we're doing and whether we're doing it as well as we can. That's basic, and most of us do that. The next step that we have to take is a willingness to do something about problems when we see them. That's coming more slowly, but it's coming. There aren't any real black-and-whites. All you know is there's an aberrancy. The

And, that's remediation enough. Just pointing out the aberrancies.

The next step that we have to be willing to take is that if somebody is really aberrant, it's incumbent upon the profession to do something, even unto eliminating that person from their profession. That's a very hard line, but, as you know, it just irritates me to read in the paper about people who have been found guilty of felonies and find they're still members of the state medical society. That is unconscionable, and I don't think we can allow that to happen. We must peer review those people and if their aberrancy is of such a magnitude as to be unacceptable, we need to say so. We need to be able to bite the bullet and do something about it. That, too, is protecting the public.

That's our difference, and the difference, again, with the trade union, is that they would gather around the wrongdoer and say, "he's one of us, we'll protect him." We, as a profession, should not do that. We should say, "this person is wrong, even though he is a doctor, you know, he's less than God-like, and we recognize that and want to do something about it."

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***"... if somebody is really aberrant, it's incumbent upon the profession to do something, even unto eliminating that person from their profession. . . . We need to be able to bite the bullet and do something about it. That, too, is protecting the public."***

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**IMJ:** *It's been said that medical education is threatened by reduced federal student loan funds. Do you have any opinion, as an educator, about how the decision should be made as to who has access to those funds for scholarships, and how the academic branch is going to respond to the decreased monies coming in?*

once you get over the ego step, to be able to look at your practice in comparison with your peers in the area, with a larger area, with the universe, and say, "hey, maybe I can do something better." U.R., I think, is a logical part of that, and I think that physicians are coming to accept that kind of thing. It used to be, "I'm the doctor, I do everything, and I know everything." I think—I hope—that attitude is fading away.

next step is to find out why, and I think we're approaching that better now. The harder step is what to do about it, and the first step there ought to be remediation. Is this person educable? Can you talk to him? Can you straighten out his practice? And very often pointing out to the physician that, "hey, you're doing twice as many of this test as anybody else," is enough for him to say, "gee, I didn't know that, I wonder why."

**Dr. White:** Let's divide that and talk about the funding of student scholarship loan programs. Very briefly, what's happening there is that tuition is going up. I read that Georgetown is now at \$19,000 a year tuition. The loan funds for students are shrinking. What that's going to do, very simply, is to squeeze out everyone except those who are independently wealthy. That's bad because that's not where most of us came from. There aren't very many

independently wealthy medical students, and it would obviously squeeze out people who could be very able physicians.

So there's a need for funds from some other source, and I don't know where it's going to come from. It's not going to come from the government, and that's the reason I've been very anxious to get a loan fund provision from the Society. We've done that with the ISMS/IAA (Illinois Agricultural Association) program, and it's excellent. It does everything that it does very well, but it's a limited group of people. There should be a way, and I hope the Educational and Scientific Foundation can enrich or supplement the stipends or loans from other programs. I don't see us developing our own bureaucracy for eligibility, but rather developing capital funds that could then be loaned to existing loan funds. For example, if the stipend for the IAA program is \$400 a month, we could loan \$100 more per month to that loan program, per student, to be paid back to the Foundation. I think the profession has a responsibility to educate others. I'm going to present a resolution asking that half of that AMA/ERF allocation from our members go to the loan fund, the other half to the deans. That's going to impact negatively on the deans' use of unrestricted funds, but we'll help students in their loan funding activity, and that's the trade-off.

**IMJ:** *You have referred to changes in the perceptions that people have about their health care needs. Is there a role for the medical society in public health education, and if so, how would you suggest we implement something like this for our membership?*

**Dr. White:** There's a role for public education, and doing that through the state society has to be on a very broad and very solid, non-specialty, non-splinter basis. It has to be in the very center of the universe. As a Society, we should talk about things to the public that do the most good for

the most people. Things like immunization, eye safety, child safety, seat belts, child restraints and 55-mile-an-hour speed limits. And again the same problem exists, in that the emotional things are at the end point. You just can't get a lot of enthusiasm about putting on seat belts or child restraints. Maybe statewide public service announcements could be written. Also, we can encourage people to use the medical system appropriately. We'd have to be careful and thoughtful about how we did that. That alone would be very help-

same problems every month or so, maybe I'm not doing so badly.

**IMJ:** *Let's talk about doctors as citizens and access to the legislative process. What would you tell members who have not been active about getting involved with the legislative process?*

**Dr. White:** Two words: do it. The thing that has struck me this year—and I don't think it's because I've been president but because I've been

---

***"The loan funds for students are shrinking. What that's going to do . . . is squeeze out everyone except those who are independently wealthy. That's bad, because that's not where most of us came from."***

---

ful to the profession, to the cost of medical care and to the patients. We should demonstrate a presence of the medical society to the public. We don't do that now. That's not a criticism. It's just that we've been busy putting out brush fires, but maybe now we should look ahead.

**IMJ:** *Practicing medicine includes teaching prevention.*

**Dr. White:** Most of us should function much like teachers, allowing people to understand their own problems and how to deal with them. Many physicians become irritated with patients because they don't follow advice and then return with the same complaints. Every time that irritability rises up in me, I remember that we go to church every Sunday. Now, if we only had to tell people *once* to be good, then we wouldn't have to have church every week. So, if people come back to me with the

a doctor and talked to legislators—is that the legislators are almost anxious to hear what I have to say. Not because it's me, but because they don't hear that much from real live doctors. They hear from our legislative people, and because they hear from them frequently, it's a little bit like a mother shouting at a child. They tend to get used to those voices and tune them off after a while. It doesn't have the same impact that a physician does. Without exception, every time I've talked to legislators, they've been willing listeners. I don't know if I swayed any of them, but I felt very good about the fact that they wanted to hear. I think physicians who want to get involved will find the same thing.

I think it's important not to call only when you've got a problem, or to complain, but on occasion to say, "hey, what you did last week was really great. I appreciate it." And, if you do call and ask for something and they do it, then close that loop by calling or writing later and saying



thank you. It's a good feeling, something that physicians can get involved in. In that arrangement I think physicians are a little bit like the patient with the doctor. The patient is to the doctor as a doctor is to the legislator. The patient doesn't call because the doctor may be busy. The doctor assumes that the legislator may be busy: "he might get angry with me. He won't listen to me."

I think when most people do call their doctor, they find willing listeners who do want to help. The same thing is true with the legislators. But if you don't call or write to them, you'll never know.

**IMJ:** *I would suppose there are a lot of legislators who would like to hear someone say, "next time something comes up that relates to health, and you're not sure, call me."*

**Dr. White:** Absolutely. It gives them a resource. And that's to their benefit, because then they can say, "I discussed this with physicians in my area and I feel that I'm on solid ground. This is what they think." It does something for them, so it's not

exercise as a society, two years ago, and I would hate to think that it was just an exercise. I think that the Society requires goals and that they must be reviewed periodically. I would hope that the staff and the leadership would periodically take

terms of block grants? Block grants have been upon us for a year and a half and we, as a Society, do not have any goals.

What goals do we have in regard to the population that can't pay for medical care? We've been reacting

---

***"We can't say "this is our position and we'll stay there." We have to keep looking at alternatives and keep choosing among those . . . the process is more important than the outcome. As long as we stay . . . open and reasonable, we are secure."***

---

some time out to look at the existing goals, and see whether they're appropriate and whether there are activities that should be undertaken to arrive at those goals. We must keep looking at them.

Unfortunately, we get so busy with

and negotiating and discussing with public aid for at least a decade. That has been helpful, but we haven't really looked ahead. We've made shots at it. We said that it might be more beneficial to take care of the older person at home, and pay someone, some family member, to take care of them. That might be better than keeping them in a nursing home. We've said that, but we haven't really developed any programs to present. We haven't done those pro-active sorts of things that we should do.

So, I do think that we need to pay attention to our goals and need to develop pro-active programs.

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***"I think when most people do call their doctor, they find willing listeners who do want to help. The same thing is true with the legislators. But if you don't call . . . you'll never know."***

---

an all "take" position on the part of doctors.

**IMJ:** *As you leave the office of president, what kind of goal setting would you recommend for the Society?*

**Dr. White:** We went through this

what we need to react to that we don't really have any pro-active programs. The only way I know to do that is to take some time aside with planning as the sole agenda. I think we need pro-active programs. We need to be looking ahead to what we as a Society should do. Do you know what goals we have developed in

**IMJ:** *I was rereading some things you'd written this year in order to find a central theme. Over and over and over, you've said, "let's be reasonable. Let's be rational, let's respond intelligently, let's not be rigid." Now that you're concluding the year, and have a better idea of the forces and constraints than anybody else, what would you tell your successor, Dr. Wiggishoff, about where the voice of reason is going to be? Where will he find the biggest challenges to his sense*

*of balance and perspective? Where do you see the greatest danger and threat to that flexible perspective?*

**Dr. White:** I don't think there is any threat. I think the things we have to do are the very things that you mentioned—be reasonable, not stay with the fixed position, and not consider our own needs as a society or as a profession in a vacuum. We have to consider our needs in the whole social context so that we—and I think that's where the reasonable, flexible sort of attitude comes in—consider the alternatives. We can't say, "this is our position and we'll stay there." We have to keep looking at alternatives and keep choosing among those. I guess, in my view, the process is more important than the outcome. As long as we stay with the process and stay open and reasonable, we are secure. We don't have to deal for our own position in society because what we have is a

profession in a society that is very responsive to that profession in its own way.

In fact, let me diverge a minute. The medical society has to be conservative because of the inertia inherent in a large group. It can't respond immediately. It's a big organism and it comes along slowly. Things have to begin at the local level and work up, and that takes time. I keep saying our problem is our success. The state society is so democratic, and that's a great strength, but it's also a problem because you can't get things moving. It's not nearly as quick as a benign dictatorship, but it needs to be that way. We have to recognize that and allow for it, but still keep options open.

We have to stay involved in the process, in all processes, in the state process, in the medical society process, in the social process. It will probably seem to my successor that I'm condemning him to a year of going to meetings, and I am. And the

reason I am is that unless you do, you can't keep your perspective, see the rest of the world and get other people's points of view. You stay in your own tunnel. You have to really be exposed to those other things to begin to get some of the other people's points of view. And unless you look at yourself from others' eyes, or from others' positions, you don't have a good view of yourself. You lack the mirror.

**IMJ:** *That's probably also the best argument for professional society membership.*

**Dr. White:** Exactly. And it's also the best argument for the strength of the Illinois State Medical Society. The more specialty societies we have, the stronger the Society. You know the old diagram—two small circles and a center linking circle. We're the center circle and the more small circles there are around us, the more relevant and strong we can be. ◀



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## EKG

(Continued from page 241)

Answers: 1. E 2. E

All of the ECG answers are correct. The qR pattern seen in lead V<sub>1</sub> is compatible with right ventricular hypertrophy and frequently reflects systemic pressures in the right heart. The QRS axis is rightward at approximately +110°. The PR interval measures 0.30 seconds compatible with marked first degree atrioventricular block. The large negative P wave in lead V<sub>1</sub> suggests left atrial enlargement.

All of the answers in question two are correct. Many patients may survive to adulthood with tetralogy of Fallot. In this patient, the posterior thorax systolic thrill was probably due to bronchial collateral circulation while the precordial systolic murmur was caused by the ventricular septal defect. The pressures measured at the time of cardiac catheterization were: right ventricle 115/14mmHg, left ventricle 120/8mmHg. The pulmonary artery could not be entered. A right ventricular angiogram showed severe pulmonic infundibular stenosis and a ventricular septal defect high in the intraventricular septum. The coronary arteries and the left ventricle were normal. Total correction of tetralogy of Fallot in patients over age 30 can be performed successfully. However, perioperative and late mortality rates are in the range of 10-20%, in part due to myocardial dysfunction and ventricular arrhythmias. A recent histological evaluation of the crista supraventricularis (infundibular myocardium) in these patients showed cellular atrophy, myofibrillar lysis and interstitial fibrosis. These changes were not present in children with tetralogy of Fallot. Our patient was recommended for surgical repair. (See Jones and Ferrans, "Myocardial Degeneration in Congenital Heart Disease," *Amer Journal of Cardiology* 39:1051, 1977).

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## Viewbox

(Continued from page 249)

### Diagnosis: Pseudomembranous Colitis

Examination of Figure 1 reveals colonic dilatation with evidence of thickened folds and "thumbprinting". This combined with a history of recent antibiotic use makes pseudomembranous colitis the most likely diagnosis. While toxic megacolon causes "thumbprinting" there is often evidence of pseudopolyps and ulceration. In colonic ischemia one may see thumbprinting and occasionally intraluminal or portal venous gas. In the radiograph above, air can be seen to the level of the rectum with a normal sized sigmoid colon, which makes mechanical obstruction an unlikely possibility.

As the name would imply pseudomembranous colitis (PC) is a form of inflammatory disease associated with plaque-like pseudomembranes adherant to the colonic mucosa. It is now well recognized that PC is related to antibiotic therapy. The normal colon is inhabited by a variety of micro-organisms, each competitively inhibiting the other's growth. If an agent is introduced into the colonic environment and selectively removes a certain group of bacteria, overgrowth of the remaining microorganisms is the consequence. By this mechanism various antibiotics (Table 1)<sup>1,2</sup> (most notably clindamycin) reduce the intracolonic populations of the anaerobic species of *Bacteroides* allowing overcolonization of the large bowel by *Clostridium difficile*, an obscure member of the anaerobic clostridium genus. *C difficile* can often be cultured from the stool of patients affected with pseudomembranous colitis. The same stool sample when injected intracecally in hamsters produces a disease state identical to PC.<sup>3</sup> *C difficile* has been shown to elaborate an exotoxin which is found in feces of affected patients and is readily detected by its cytotoxicity in tissue culture.<sup>3-5</sup> The cytotoxic effect of the exotoxin produced by an abnormally large population of *Clostridium difficile* causes the inflammation seen in pseudomembranous colitis.

Patients usually complain of watery mucous-like diarrhea and crampy abdominal pain. Blood is so infrequently seen in the stool that its presence should suggest some other etiology.<sup>6</sup> Occasionally,

Table 1  
Antibiotic Induced  
Pseudomembranous Enterocolitis

Lincomycin  
Clindamycin (Chlorinated analog of Lincomycin)  
Ampicillin  
Cephalosporins  
Sulfa Drug  
Amoxicillin  
Sulfamethoxazole/Trimethoprim Combinations  
Other Synthetic and Non-Synthetic Penicillins  
Chloramphenicol  
Tetracycline  
Rifampin

diarrhea is not a prominent feature and a clinical picture more consistent with paralytic ileus is encountered. The patient classically relates a story of recent antibiotic use, either oral or parenteral, and usually becomes symptomatic 4-9 days following initiation of therapy. Physical examination may reveal an acute abdomen in patients with varying degrees of toxemia. Leukocytosis and fever are common. The diagnosis rests on the endoscopic demonstration of discrete to confluent yellow plaque-like pseudomembranes 2-7mm in diameter. The intervening mucosa is normal to erythematous. Pinpoint mucosal bleeding occurs when these plaques are raised. Total colonic involvement is classic but the rectum may occasionally be spared.

Light microscopic examination reveals an acute inflammatory infiltrate with scattered areas of epithelial erosion and necrosis, but without ulceration.<sup>7</sup> Thrombosis of vessels does not occur. The lamina propria is edematous with infiltration by polymorphonuclear and mononuclear leukocytes. An exudate of fibrin and mucus is characteristically present. There are increased numbers of mucous-laden goblet cells.

Plain films of the abdomen may show non-specific contour defects of the gas filled colon.<sup>8</sup> These contour abnormalities consist of "thumbprinting" produced by thickened haustra outlined by bowel gas. The bowel may be dilated. Minimal small bowel abnormalities are sometimes seen. The plaque-like pseudomembranes may be seen in profile superimposed on the thickened "thumbprinted" colonic wall. Toxic megacolon has been reported as a complication of pseudomembranous enterocolitis.<sup>9</sup> Barium examination of the colon is contraindicated if there are obvious signs of sepsis, peritonitis, or perforation. It is relatively contraindicated even in the absence of



these more ominous signs due to the threat of converting PC to toxic megacolon as a result of the enema. Nevertheless, at times contrast examination of the colon may be required to make the proper diagnosis. In these instances barium examination confirms thickening of the bowel wall and demonstrates plaque-like to nodular rounded filling defects 2-7mm in diameter.<sup>1</sup> Total colonic involvement is characteristic and the mucosal surface may have an almost "shaggy" contour. There are no ulcerations. Conceivably, air contrast barium examination would better demonstrate the discrete mucosal plaques so characteristic of this disease, but large amounts of mucous usually inhibit proper mucosal coating by barium required for this study.

Treatment begins with the discontinuation of antibiotic therapy. Mild cases frequently resolve spontaneously but oral Vancomycin is often required.<sup>10</sup> Vancomycin is not well absorbed when orally administered and is thus effective in removing *C difficile* from the colon without significant systemic levels. A positive clinical response is expected within 7-10 days with endoscopic clearing of pseudomembranes. Glucocorticosteroids have no place in the treatment of PC and may even be contraindicated. ◀

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**Pregnancy and Lactation:** Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

**PRECAUTIONS** — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

**ADVERSE REACTIONS** — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

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*Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.*

## Carotenemia

*To the Editor:*

The case report on carotenemia by Dr. S.J. Sugar was recently brought to my attention (*IMJ*: 158 p.356, November, 1980). I would like to clarify two points concerning carotenemia brought up in this report.

It is well established that vitamin A toxicity is not seen in individuals using carotenoid-containing vegetables, or preparations of pure beta-carotene, as their sole source of vitamin A.<sup>1</sup> It should be noted that the patient mentioned in the paper quoted in the case report<sup>2</sup> had been taking 90,000 IU of vitamin A per day for four years in addition to carotenoid-containing vegetables. A likely explanation for the elevated vitamin A level in the patient ingesting large amounts of pumpkin was the recognised observation that high levels of blood carotene can give falsely elevated levels of blood vitamin A in some of the laboratory tests for this vitamin.<sup>3</sup> Thus, the clinical laboratory should be questioned about whether this interference is corrected for when high levels of vitamin A are reported in carotenemic patients who are not taking vitamin A supplements. It is also important to ask carotenemic patients whether they are also taking vitamin preparations containing vitamin A.

As to carotenoids and vitamin A levels and cancer, recent studies, including the one quoted in the case report,<sup>4</sup> suggest that human cancer risks are inversely correlated with blood retinol levels and dietary beta-carotene. For a review of this intri-

guing subject, the reader is referred to the article by Peto.<sup>5</sup> It is important to note that blood retinol levels in the higher ranges of normal are all that is needed to obtain this protective effect. Thus, there is no need to take more than the minimal daily requirement of vitamin A (5,000 IU/day) or of its carotenoid precursors (10,000 IU/day of carotene).<sup>1</sup>

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Micheline M. Mathews-Roth, M.D.  
Harvard Medical School  
Boston, Mass., 02116

### *The Author Responds:*

Dr. Mathews-Roth raises important and enlightening points with regard to Vitamin A toxicity and carotenemia. Especially important is the warning for clinical laboratories

to correct for falsely evaluated levels of blood Vitamin A in patients with high blood carotenes. Her comments reinforce the main thrust of the paper, namely that a careful dietary history is critical when evaluating patients with Xanthochromia.

Sincerely,  
Sam J. Sugar, M.D., F.A.C.P.

## More Smoke

*Editor's Note: The correspondent refers to a five part series published on the Medical Student Section page in late 1980 and early 1981.*

*To the Editor:*

Ronald M. Davis, Delegate, ISMS/SBS, is remarkably naive. For him, the world still revolves around regulation. I suspect he sees things as black and white, with little gray.

Instead of concentrating on the fire breathing, regulatory dragon approach to societal improvement, I would like to suggest to him that he become more acquainted with another direction. It is well outlined in a number of publications, perhaps the most lucidly by Jay W. Forrester in *Technology Review*, Vol. 1 73, no. 3 (Jan. 1971).

For Mr. Davis' information, I am an avid non-smoker.

Sincerely  
J. James Walch, M.D.  
Hoffman Estates

### *The Author Responds:*

I would agree that there is some truth to the claim that a fire-breathing dragon has sat at the helm of the regulatory agencies in the recent past.

But whereas Dr. Walch would probably prefer to slay the dragon, I believe that the country's best interest would be served by merely taming the beast.

The effectiveness and fairness of the marketplace vary depending on the product being sold. Where the market is imperfect, regulation is often justified, and at times, obligatory.

If I desire to purchase a dozen roses, the market works quite well. I can scan the newspapers or "Yellow Pages" for florists' advertisements. I would feel reasonably confident that those ads would not be deceptive. At the store, any inferior goods would be obvious on casual inspection, and I would reject them. If the flowers wilted prematurely—either sooner than what was advertised, sooner than what I had been told by the florist to expect, or before what I thought was a reasonable period of time—I would be aware of that fact within a few days, and I would remember not to stop at the same florist again. If other shoppers did the same, the florist would soon be forced to improve the quality of his wares, lower the prices, or go out of business. I would not become physiologically addicted to the product, and it would not cause me disability, disease, or death (unless, of course, I used it for other than its intended purpose). Finally, the roses would not harm those who, through no fault of their own, happen to come within their vicinity. Thus, regulations governing the sale of roses are not necessary.

On the other hand, the cigarette marketplace—like many other aspects of the health care marketplace—does not work so well. Most smokers begin the habit in adolescence, overcome by peer pressure, parental role modeling, and societal indifference. Worst of all, though, is that teenagers and adults are influenced by the most massive advertising campaign in the history of civilization, to the tune of one billion dollars per year in the United States. Furthermore, the ads are virtually unregulated by government. It is therefore not surprising that they are blatantly deceptive in their depiction of smoking as not just sexy and sophisticated, but compatible with (if not responsible for) good health and

long life (e.g., those who smoke Newport are "Alive with Pleasure!").

Anti-smoking education, by contrast, is miniscule. Fewer than three million dollars are spent each year in the United States by the government and voluntary agencies combined, less than the amount spent by the tobacco industry on cigarette advertising in a single day.

The Surgeon General's 14-word warning is scarcely noticed anymore, worn out for want of its own badly needed "Madison Avenue" rejuvenation. Moreover, as any physician should know, it fails miserably to adequately inform consumers of the severity and multiplicity of tobacco's effects on health. A recent Federal Trade Commission staff report on cigarette advertising showed incontrovertibly that the public is woefully ignorant of the dangers of smoking.

Even if the dangers of smoking were well publicized, what about the teenager who becomes physiologically addicted to nicotine long before he may be capable of understanding how emphysema or lung cancer impacts on the quality or duration of life? Nowhere is the potential smoker warned of the addictive nature of tobacco, not to mention the probability that many teens don't even know what an "addiction" really is. How can we expect adolescents to avoid a product that will not affect them for 20, 30, or 40 years when youth-oriented advertising has virtually monopolistic control over their sensory input?

What about cigarette manufacturing? Does the free market serve the public interest in this area? The manufacture of cigarettes, unlike that of almost all other foods or products sold in the country, is totally unregulated. Evidence is now surfacing that, in addition to the carcinogenic agents naturally present in tobacco, some are being *added* to the cigarette during the manufacturing process to enhance taste, promote burning, etc. The companies refuse to divulge information on these additives because of alleged "trade secrets." Our only means to acquire such information is through expensive (unsubsidized), time-consuming, and inefficient research. They could be adding saccharine, cyclamates, red dye #2, or diethylstilbestrol (DES) to cigarettes and, under the present circumstan-

ces, we would never know about it.

I have not even touched upon the effects of smoking on the nonsmoker, the astronomical impact of smoking-related diseases on rising health care costs, the alteration of cigarettes to prolong burning (and promote fires), and so on. In the face of all this, can anyone logically argue that a free market in "Marlboro Country" will lead to societal improvement? I maintain that it will ensure societal deterioration.

Contrary to Dr. Walch's assertion, I do see quite a bit of gray. But most of the gray that I see is in the 320,000 corpses of those who die from cigarette-related diseases each year in the United States.

Ron Davis  
Chicago

## Nothing Succeeds Like . . .

Dear Fred:

I just finished reading the President's page in the January issue of the *Illinois Medical Journal*, which, by the way, I have read faithfully since you have been president, and wish to congratulate you on this superb presentation.

I intend to suggest to Gene Hoerr and John Hanni that this be circulated widely among both our medical and lay community.

Thank you for your continued efforts on our behalf.

Yours sincerely,  
Henry A. Boldt, M.D.  
Peoria

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Dear Fred:

I read your letter on the President's Page (Vol. 161, No. 1, Jan 1982) with intense interest and pride in your masterful expression.

The title, "Success is Our Problem," was so appropriate.

Congratulations on an excellent presentation.

Best wishes to you personally and for your sound leadership of our Society.

H. Close Hesseltine, M.D.  
Centerville, Iowa



# IMPAC

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# Doctor's News

**LICENSE RENEWAL REMINDER AND CORRECTION**—Contrary to an earlier report in a recent issue of *IMJ*, representatives of the Illinois Department of Registration and Education have announced that all Illinois medical licenses will be subject to renewal by the Department before July 1, 1982. (Earlier announcements had erroneously set the renewal date at July 31.)

The Department mails license renewal forms to the "address of record," that is, the address listed by the physician at the time of 1980 license renewal. If the mailing address has changed in the interim, the physician is obliged to notify the Department.

Illinois law requires that continuing medical education (CME) credit be earned during the two year period ending March 31, 1982. At least 50 hours of Category 1 CME credit and an additional 50 hours of Category 2 credit must be earned by each physician during the two year period from April 1, 1980 through March 31, 1982. Of the 50 hours Category 1 credit, a minimum of 20 must be part of an approved, formal educational program as specified in the Medical Practice Act. The balance may fall into the realm of approved teaching or medical care audit activities.

Failure to renew on time results in a late fee penalty, and also could jeopardize liability insurance coverage. Further information may be obtained by contacting the Medical Licensure Section, Department of Registration and Education, 320 W. Washington St., Springfield, 62786; (217) 785-0800.

**SPORTS MEDICINE MEETING**—ISMS members are invited to attend the School Liability Conference at the Holiday Inn East, Springfield, on Wednesday, May 26 from 9:30 a.m. to 5:30 p.m.

Dr. Kenneth Clarke, Director of Sports Medicine for the United States Olympic Committee, will be the keynote speaker. Topics discussed will include liability for injury, the physician's role in preventing and responding to injuries and prescriptions for post-injury care.

The conference, co-sponsored by University of Illinois College of Applied Life Studies and the Illinois Association of School Boards, is designed for school board members, administrators, and teachers as well as attorneys and doctors.

Registration fee is \$45.00. For further information contact Don Arnold, conference coordinator, at (217) 333-4561, University of Illinois at Urbana-Champaign, College of Applied Sciences, Department of Physical Education, 906 South Goodwin Avenue, Urbana, 61801-3895.

**HMO-IPA SLIDE PROGRAM**—Interested in Health Maintenance Organizations (HMOs) and Individual Practice Associations (IPAs)? The ISMS slide show on these two systems of health care delivery is available for presentation. Lease of the slide show is free of charge to county medical societies. To reserve the ISMS slide program send a written request to: Illinois State Medical Society, Division of Professional Relations, 55 E. Monroe St., Suite 3510, Chicago 60603. Please allow 30 days for delivery.

**MARRIAGE STATUTE CLARIFIED**—IDPH has attempted to clarify language in the new marriage statute which became law on January 1. The statute requires marriage applicants' medical examination to include a laboratory test for syphilis. However, a copy of the report need not be presented to the county clerk with the physician's certificate. IDPH interprets receipt of the signed physician's certificate to mean that the physician believes the patient to be free of transmissible syphilis at the time of the examination. It is understood that the physician cannot guarantee that the patient will not contract syphilis in the future.

The syphilis test must be performed by a laboratory approved by IDPH. A list of IDPH-approved laboratories may be obtained by contacting Dr. Robert Martinek, IDPH Laboratory, 2121 W. Taylor, Chicago 60612 or (312) 793-4750.



**PHYSICIANS IN THE NEWS**—**J. Robert Buchanan, M.D.**, Chicago, has been named general director of Massachusetts General Hospital, Boston, effective July 1. Dr. Buchanan has been president of Michael Reese Hospital and Medical Center since 1977 . . . **Drs. Gustavo Abello, Sroga Bharati, Prabir R. Roy, Siveraramaprasad Tummala** and **Joseph V. Messer**, all of Chicago, **Rosula R. Rajendran**, Berkeley, **William D. Richardson**, Troy, and **Ved P. Yadava**, Willow Springs were formally inducted as fellows of the American College of Chest Physicians at the ACCP's 47th Annual Scientific Assembly . . . **Francis C. Murphy, M.D.**, Park Ridge, was recently presented with the third annual Donald L. Kessler Leadership Award by the medical staff at Saint Joseph Hospital, Chicago.

**Morris T. Friedell, M.D.**, Chicago, chairman, ISMS Board of Trustees, was awarded the first annual Dr. Morris Fishbein Award on December 21. Dr. Friedell, past president of the Chicago Medical Society, is the son-in-law of the late Dr. Fishbein, who was also a past president of CMS and the former editor of *JAMA*.

**James B. Malow, M.D.**, Chicago, has been appointed director of medical education at Illinois Masonic Medical Center, Chicago, where he also serves as director of infectious diseases, department of internal medicine.

**Thomas C. Schrepfer, M.D.**, Havana, was successful in his bid for the Republican nomination for State Representative, 91st District, in the March 21 Illinois Primary Election. Dr. Schrepfer, who is secretary of the Fulton County Medical Society, is a founding member of the Mason County Board of Health and a clinical associate professor for the SIU School of Medicine, Peoria.

Medical staff officers for 1982 at St. Anne's Hospital, Chicago, are **John P. Igini, M.D.**, Elmwood Park, president; **Bernard Coniglio, M.D.**, River Forest, president-elect; and **Elio Vento, M.D.**, Oak Park, secretary-treasurer.

**Jacob R. Suker, M.D.**, chairman, American Council on CME-Illinois, is one of six members on the newly approved ad hoc State/ACCME Relations Committee. ACCME established the group to handle questions regarding relationships between the ACCME and state medical societies.

**Eugene L. Vickery, M.D.**, Lena, has been voted Illinois Family Doctor of the Year. Dr. Vickery, long an active member and Council chair for ISMS, was also one of ten finalists for AAFP American Family Doctor of the Year.

**Hugo Velarde, M.D.**, Chicago, president of the Northwest Branch, Chicago Medical Society and Northwest Chapter, Illinois Academy of Family Physicians, has been elected chairman of the Department of Family Practice at St. Elizabeth's Hospital, Chicago.

**CME NEEDS**—Continuing medical education program planners can learn more about educational methods during the "CME Needs Identification, Goals and Objectives" seminar May 21-22 at the Drake Oak Brook Hotel, Oak Brook. The workshop, sponsored by the Illinois Council on Continuing Education, (ICCME) is designed primarily for physicians who are responsible for planning and implementing CME programs as well as non-physician CME planners and education specialists interested in physician learning activities. Among the activities are small-group discussion and problem solving, identification strategies and development of valid CME program goals. Registration is limited to 24 participants. For more information contact ICCME, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

**CONTROLLED SUBSTANCES LICENSES**—The Illinois Department of Registration and Education has announced that proposed rules changing the renewal period for controlled substances licenses from annual to biennial are under consideration. The proposed rules would establish the same renewal date for both licenses to dispense controlled substances and for superior professional licenses. Expiration dates for other controlled substances licenses would be December 31 of each even numbered year.

The new regulation was published in the March 12 *Illinois Register*, and a 30 day comment period was permitted. Information concerning any action taken on the proposal will be carried in an upcoming issue of *IMJ*.

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# Guide to Continuing Medical Education

## MAY

### Anesthesiology

#### Midwest Anesthesiology Conference

**For:** MD's. Lectures, May 6-8, Chicago Marriott Hotel. **Sponsor:** Illinois Society of Anesthesiologists, c/o Michael Reese Hospital, 29th St. and Ellis Ave., Chicago 60616. **Reg. deadline:** none. **Reg. limit:** none. **Credit:** Category 1, 17-23 hours. **Contact:** William Gottschalk, MD. **Phone:** 312/942-6503.

### Anesthesiology

#### Regional Anesthesia

**For:** Anesthesiologists. Lecture, May 10 (5 days), Chicago. **Speaker:** Alon Winnie, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 20. **Credit:** Category 1, 45 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Anesthesiology

#### Specialty Review in Anesthesiology

**For:** Anesthesiologists. Lecture, May 10 (6 days), Chicago. **Speaker:** Alon Winnie, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$525. **Reg. limit:** 300. **Credit:** Category 1, 52 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Cardiovascular Emergencies

#### Annual Scientific Session

**For:** MD's, RN's. Lecture/workshop, May 13-14, Ramada Convention Center, Champaign. **Sponsor:** American Heart Assn., 1181 N. Dirksen Pkwy., Springfield 62708. **Cosponsor:** SIU School of Medicine. **Reg. deadline:** 5/6. **Fee:** \$65. **Reg. limit:** 250. **Credit:** Category 1, 10 hours; AAFP Elective, 10 hours. **Contact:** A. Paul Naney, MD. **Phone:** 217/525-1350.

### Endocrinology

#### Diagnosis & Treatment of Hyper- and Hypothyroidism

**For:** MD's. Lecture, May 21, 8:00 a.m., Chicago. **Speaker:** Theodore Schwartz, MD. **Sponsor:** Grant Hospital, 550 W. Webster Ave., Chicago 60614. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Sharon Smith. **Phone:** 312/883-2112.

### Family Medicine

#### 34th Annual Postgraduate Seminar

**For:** FP's. Annual Meeting, May 23-27, Hyatt Regency, Chicago. **Sponsor:** Illinois Academy of Family Physicians, 1200 Harger Rd., Suite 405, Oak Brook 60521. **Fee:** Member, \$0; Non-Member, \$25. **Reg. limit:** none. **Credit:** Category 1, 12-22 hours; AAFP Prescribed, 12-22 hours. **Contact:** H. Marchmont-Robinson, MD. **Phone:** 312/325-8502.

### Family Practice

#### Caring for the Older Patient

**For:** MD's. Symposium, May 11, 7:00 p.m., Effingham. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$30 pre. **Reg. limit:** none. **Credit:** Category 1, 3 hours; AAFP Prescribed, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Internal Medicine

#### Lake County Medical/Surgical Seminar

**For:** MD's. Seminar, May 19, Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan 60085. **Reg. limit:** none. **Reg. deadline:** 5/17. **Fee:** \$5. **Credit:** Category 1, 4 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312/578-2555.

### Medicine

#### First Annual Oncology Symposium

**For:** MD's. Symposium, May 7-8, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Medicine

#### Cardiology Update

**For:** MD's. Symposium, May 22, 1:00 p.m., Marion. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$35 pre. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Medicine

#### What is Happening in Cardiology

**For:** MD's. Symposium, May 28, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Medicine

#### Chronic Gastrointestinal Complaints

**For:** MD's. Symposium, May 5, 6:00 p.m., Maryville. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$35 pre. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Neuroradiology

#### 1982 Neuroradiology Review Course

**For:** General Radiologists, Neuroradiologists, Neurosurgeons. Course, May 1-2, Drake Oakbrook. **Sponsor:** Loyola University Medical Center, CME, 2160 S. First Ave., Maywood 60153. **Fee:** \$125; \$75, Residents. **Credit:** Category 1, 15 hours. **Contact:** Behrooz Azar-Kia, MD. **Phone:** 312/531-3928.

### OB/GYN

#### Reproductive Endocrinology

**For:** MD's. Symposium, May 15, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$80 pre. **Reg. limit:** none. **Credit:** Category 1, 6 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### OB/GYNE

#### Specialty Review in Ob-Gyne

**For:** Obstetricians, Gynecologists. Lecture, May 17 (5 ½ days), Chicago. **Speaker:** M. LeRoy Sprang, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$425. **Reg. limit:** 300. **Credit:** Category 1, 44 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Radiology

#### Specialty Review in Radiology

**For:** Radiologists. Lecture, May 17 (5 days), Chicago. **Speaker:** Rogelio Moncada, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Surgery

#### Trauma Surgery: in the ER, OR, and ICU

**For:** General Surgeons. Symposium, May 12-14, Chicago. **Sponsors:** U of I College of Medicine; Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Reg. deadline:** 5/12. **Fee:** \$275. **Reg. limit:** 300. **Credit:** Category 1, 19 hours. **Contact:** Robert Baker, MD. **Phone:** 312/996-6765.

### Surgery

#### Care of the Amputee Patient—A Multidisciplinary Approach

**For:** MD's. Symposium, May 1, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Surgery

#### Sports Injuries IV

**For:** MD's. Symposium, May 15, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$80 pre. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Trauma

#### Fractures and Other Trauma

**For:** Ortho./General Surgeons, GP's, Emergency Physicians. Course, May 12-14, Chicago. **Speaker:** Charles Edwards, MD. **Sponsor:** Chicago Committee on Trauma of the American College of Surgeons. **Cosponsor:** American Academy of Emergency Physicians. **Fee:** \$100-\$350. **Credit:** Category 1, 24 hours; ACEP, Category 1, 24 hours; AAFP Elective, 21 hours. **Contact:** Jack Robbins, MD, 2500 Ridge, Evanston 60201. **Phone:** 312/475-4040.

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# JUNE

## Diabetes

### Diabetes Mellitus—1982

**For:** Primary care physicians. Symposium, June 4-5, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** TBA. **Reg. limit:** none. **Credit:** Category 1; AAFP Prescribed, AOA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Emergency Care

### Cardio-Pulmonary Resuscitation Update

**For:** MD's. Lecture/demonstration, June 25, 11:00 a.m., Oak Park. **Sponsor:** CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Charles Weigel, MD. **Phone:** 312/366-7870.

## Endocrinology

### Under- and Overactive Adrenal Function

**For:** MD's. Lecture, June 4, 8:00 a.m., Chicago. **Speaker:** Will Ryan, MD. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Sharon Smith. **Phone:** 312/883-2112.

## Family Medicine

### Specialty Review in Family Practice

**For:** FP's. Lecture, June 1 (11 days), Chicago. **Speaker:** Harry Marchmont-Robinson, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$600. **Reg. limit:** 200. **Credit:** Category 1, 98 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Family Practice

### Practical Office Oncology

**For:** FP's. Lecture, June 11 (1 ½ days), Chicago. **Speaker:** John Merrill, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$175. **Reg. limit:** 90. **Credit:** Category 1, 12 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Family Medicine

### 1982 Family Practice Update

**For:** MD's. Course, June 21-25, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, CME, 600 S. Paulina, Chicago 60612. **Fee:** \$300. **Reg. limit:** none. **Credit:** Category 1, 30 hours. **AAFP Prescribed,** 30 hours. **Contact:** Vickie O'Sullivan. **Phone:** 312/942-7119.

## Gynecology/Surgery

### Open Laparoscopy Workshop

**For:** MD's. Workshop, June 5, 7:45 a.m., Chicago. **Sponsor:** Grant Hospital, 550 W. Webster Ave., Chicago 60614. **Reg. deadline:** 5/15. **Fee:** \$150. **Reg. limit:** 100. **Credit:** Category 1, 7 hours; ACOG, 7 cognates. **Contact:** Robert Mutterperl, DO. **Phone:** 312/883-2112.

## Internal Medicine

### Prevention of Hepatitis B Virus Infection

**For:** MD's. Symposium, June 10, St. Louis, MO. **Sponsor:** CME, Washington University School of Medicine, Box 8063, 660 South Euclid, St. Louis, MO 63110. **Fee:** \$75. **Reg. limit:** 150. **Credit:** Category 1, 6 ½ hours; AAFP Prescribed, ¾ hours; AOA, 6 hours. **Contact:** Loretta Giacobello. **Phone:** 314/454-3873.

## Internal Medicine

### Thrombolytic Therapy Symposium

**For:** MD's, Surgeons. Symposium, June 19, 8:30 a.m., Chicago. **Sponsor:** Edgewater Hospital, 5700 N. Ashland Ave., Chicago 60660. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 3 hours. **Contact:** June Gonzalez. **Phone:** 312/878-6000 x 414.

## Internal Medicine

### Lake County Medical/Surgical Seminar

**For:** MD's. Seminar, June 15, 8:00 a.m., Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan 60085. **Contribution:** \$5. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312/578-2555.

## Internal Medicine

### Problem Solving in Lung Disease: A Practical Approach

**For:** MD's. Course, June 2-4, Chicago. **Sponsor:** American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. **Cosponsors:** U of Chicago; Michael Reese Hospital and Medical Center. **Fee:** \$170-\$300. **Reg. limit:** 100. **Credit:** Category 1. **Contact:** Maxine Topping. **Phone:** 800/523-1546.

## Medicine

### Infectious Disease—What's New?

**For:** MD's. Symposium, June 3, 3:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$40 pre. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## OB/GYN

### Obstetrical Events and Neonatal Brain Injury

**For:** MD's. Conference, June 24-25, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** \$180. **Reg. limit:** none. **Credit:** Category 1, 12 hours; ACOG credit applied for; AOA, 12 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Pathology

### Advances in Developmental Abnormalities: Clinical, Genetic

**For:** MD's, genetic counselors. Symposium, June 18-19, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** \$140. **Reg. limit:** none. **Credit:** Category 1, 11 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Pharmacology

### New Therapeutics in Cardiology and Infectious Diseases

**For:** Primary care physicians, Cardiologists. Symposium, June 10-11, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, TBA; AAFP, TBA; AOA, TBA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Pulmonary Medicine

### National Board Review in Pulmonary Medicine

**For:** MD's. Seminar, June 21-25, The Palmer House, Chicago. **Speaker:** Reuben Cherniack, MD. **Sponsor:** American College of Chest Physicians, 911 Busse Hwy., Park Ridge 60068. **Reg. deadline:** none. **Fee:** members, \$350; non-members, \$400. **Reg. limit:** none. **Credit:** Category 1, 32 hours. **Contact:** Dale Braddy. **Phone:** 312/698-2200.

## Surgery

### Fluids and Electrolytes

**For:** Surgeons, Internists. Lecture, June 24 (2 ½ days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$250. **Reg. limit:** 90. **Credit:** Category 1, 23 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

# JULY

## Cardiology

### Arrhythmias and Cardiac Ischemia

**For:** GP's, FP's, Internists. Seminar, July 30-Aug. 1, Boyne Mountain Resort, Michigan. **Sponsor:** International Medical Education Corp., 64 Inverness Drive East, Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours; ACEP, 13 hours. **Contact:** Doris Price. **Phone:** 800/525-8651 x 123.

## Cardiology

### ECG Interpretation and Arrhythmia Management

**For:** GP's, FP's, Internists. Seminar, July 30-Aug. 1, the Abbey, Lake Geneva, WI. **Sponsor:** International Medical Education Corp., 64 Inverness Drive East, Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours; ACEP, 13 hours. **Contact:** Doris Price. **Phone:** 800/525-8651 x 123.

## Dermatology

### Practical Office Dermatology: A Course for Clinicians

**For:** Internists, Pediatricians, GP's, FP's. Lecture, July 12-16, Chicago. **Speaker:** Marshall Blankenship, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Reg. limit:** 85. **Credit:** Category 1, 37 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Gynecology

### Office Gynecology

**For:** Internists, GP's, FP's. Lecture, July 12-14, Chicago. **Speaker:** M. LeRoy Sprang, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$250. **Reg. limit:** 85. **Credit:** Category 1, 21 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Medicine

### Environmental Medicine

**For:** Internists, GP's, FP's. Lecture, July 19-23, Chicago. **Speakers:** Stephen Greenberg, PhD; Emerson Day, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$325. **Reg. limit:** 85. **Credit:** Category 1, 30 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Medicine

### Specialty Review in Pediatrics

**For:** Pediatricians. Lecture, July 19-24, Chicago. **Speaker:** Ira DuBrow, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 300. **Credit:** Category 1, 63 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Medicine

### Specialty Review Course in Internal Medicine/Certifying

**For:** Internists. Lecture, July 25 & Aug. 1, Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 600. **Credit:** Category 1, 72 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

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This Workshop—the second of a new and challenging series—will help you 1) select appropriate needs identification methods for your CME planning and 2) develop valid program Goals and Learning Objectives for those programs.

The Workshop is designed especially for physicians responsible for planning and implementing CME programs for their colleagues—DME's, chairmen and members of program/education committees, medical directors, department/service chiefs, medical school faculty—as well as non-physician CME planners/coordinators who are actively involved in planning CME programs, and education specialists with advanced degrees seeking more background on physician learning.

Registration is limited to 24. Learning activities include small group discussion and problem solving, individual work on specific problems, and faculty comments on major considerations of identifying learning needs and formulating valid Goals and Objectives.

For details, write or call . . .

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**U.S. AIR FORCE MEDICAL CORPS** is currently accepting applications for physicians in the following specialties: Surgery (All subspecialties), Obstetrics/Gynecology, Otorhinolaryngology, Anesthesiology, Urology, Rheumatology, Neurology, Psychiatry. For further information contact: Capt. Brian Legg (312) 263-1207. Call Collect or send CV to 111 N. Wabash, Suite 1805, Chicago, Illinois 60602.

**PRIMARY CARE PHYSICIANS** For busy suburban practice south of Chicago. Desirable setting. Target date July 1. Inquire in confidence (312) 798-3593.

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**PROFESSIONAL OFFICE SPACE** for rent in North Aurora, Ill. Professional arts building, excellent practice area, 5 min. from hospital. Medical suite 832 sq. ft., ample parking, immediate occupancy. For information call 312-892-3580.

**MEDICAL OFFICE** in growing suburban community. Three examining rooms with reception area. Pharmacy in building. Excellent location at Oak Park Mall. Ample parking. \$400.00 per month. Call afternoons: 251-3746.

**FOR SALE:** Chicago north suburban practice. Three quarter million gross billing. Located in ten thousand square foot medical center. Practice and medical center both available. Interested parties please write Mr. Lannes in care of Illinois Medical Journal, Box 1033, or phone at (312) 244-0150.

**SUBLET OR LEASE:** Psychiatric office, one block south of Wacker on Michigan. Fine view of North Side Chicago. Available between April 1 and July 1. Office is unfurnished except for waiting room furniture, which is negotiable. Call (312) 346-3790. Will return call.

**FOR SALE—REASONABLE—OFFICE** for family practice or other specialty. Located in Rockford, Illinois, in a Professional Building. This office has been highly active and functioning for forty years. Three excellent hospitals in the area. Contact: H.W. Harrison, M.D., 1221 E. State St., Rockford IL 61108; (815) 962-6312.

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**OAK BROOK AREA** Ideal medical building site within two blocks of prestigious Oak Brook Shopping Center. Fully improved 2 acre site in established growth area. \$439,000. Butler Partners. Please telephone 627-8900.

**MOUNT PROSPECT, ILLINOIS.** Recently remodeled five room suite in owner operated arts building. 550 sq. ft. or can expand. Soundproof construction. Zone controlled heat and air. Common waiting room. Near five hospitals. Ample off-street parking. 312-692-3649.

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**FOR SALE:** By owner. 47 acre farm, Barrington, Illinois. Please telephone (608) 365-4280.

**FOR RENT:** Medical office in growing suburban community. 3 examining rooms with reception area. Pharm. in building. Excellent location at Oak Park Mall. Ample parking. \$400.00 per month. Call afternoons: 251-3746.

**MEDICAL OFFICE** to sublease with option to buy in Bolingbrook. Low rent, good location. Three exam rooms, lab, reception area. For further information call (312) 739-4570 or (312) 852-1948.

**FOR LEASE:** Suite available in Professional Medical Building located in densely populated western suburb of Lisle, Illinois. Especially suitable for family practice or any other medical specialty. Respond to Box 1036, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

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**INTERESTED IN FINDING** a certified physician assistant for your busy practice? A free placement service is offered through: Illinois Academy of Physicians Assistants, 55 E. Monroe - Suite 3510, Chicago, Illinois 60603; 312-263-7150.

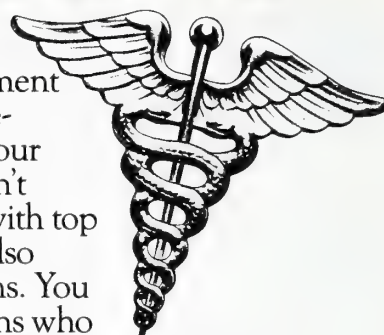
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# REPORT

## FOR *Illinois Physicians*

### Blue Cross and Blue Shield Central Certification Coverage A Guide for the Health Care Provider

Be sure to give your local Blue Cross and Blue Shield Plan these three pieces of information!

Subscriber's Name —

Group Number —

Subscriber's  
Identification Number —

		Blue Cross Blue Shield	CENTRAL CERTIFICATION
		EFFECTIVE DATE OF CURRENT COVERAGE	01 01 74
SUBSCRIBER NAME		DOE JOHN	
GROUP NO		SSK210	
CONTRACT NUMBER		SSK 123 456 789 0	

### What is "Central Certification?"

The "Central Certification" program was developed to provide uniform benefits and services to certain Blue Cross and Blue Shield members.

It is primarily used to handle the employees of a company that has all of its personnel, payroll and health coverage records in one location, but whose employees are located at plants and offices in different states, or they travel a great deal or change location frequently.

Since all Blue Cross and Blue Shield Plans in the nation-wide system may not have the exact same benefits, Central Certification was established to provide standard coverages for national companies.

All records are kept by one Plan, commonly referred to as the "Control Plan," which is usually located in the insured company's headquarters city.

The control Plan issues special identification cards bearing an outline of the United States to all employees of that company, regardless of the location.

However please be advised that a Blue Cross and Blue Shield member carrying a Central Certification card should be treated just like any local member. The Central Certification card should be accepted just the same as a card from the local Plan.

#### THE CARD

The Central Certification Card — similar to the sample at the top of the page — is different from the regular Blue Cross and Blue Shield identification card. Along with the member's name and identification number, the card also contains a six-character Group Number. The three letters identify the company where the member works and the three numbers identify the Blue Cross and Blue Shield Control Plan.



WHAT YOU DO

When a central certification subscriber comes to you for care, treat the patient exactly as you would any other Blue Cross and Blue Shield member. Give your local Plan:

the name: John Doe  
the identification number: SSK-1234567890  
the group number: SSK-210

The local Plan will then process the claim for that member.

Special Note: Report both outpatient cases and inpatient cases to your local Blue Cross and Blue Shield Plan. Most Central Certification members have comprehensive coverage, including outpatient benefits.

After the patient is discharged, or has received outpatient services, the local Blue Cross and Blue Shield Plan will reimburse you just as it would for any of its local subscribers.

PLEASE REMEMBER

Central Certification is a great convenience for a company with employees scattered throughout several states.

In almost all cases, the patient lives and works in your community.

Just remember that the Central Certification member — as you’re concerned — is exactly the same as any local Blue Cross and Blue Shield member.

You deal only with your local Blue Cross and Blue Shield Plan.

You will be paid by the local Blue Cross and Blue Shield Plan.

PLEASE NOTE!

There are several major Central Certification groups that have Blue Cross only cards. Their medical/surgical benefits are covered by other third party carriers. Following is a list of those groups with Blue Cross coverage only and the name of the carrier that covers their medical/surgical benefits. Claims should be forwarded to their carriers for medical/surgical services.

Group Name	Group ID	Carrier
Columbia Broadcasting System	CBS303	Prudential - New Jersey
Eastman Kodak Corporation	EKC304	Metropolitan
General Electric Corp.	GEC	Metropolitan
International Business Machines	90600	Prudential
Owens Illinois Glass	OIG337	Aetna
Time, Incorporate	TLE303	Traveler’s
Western Electric Corp.	WER303	Traveler’s
Westinghouse Corporation	WXB363	Equitable

K-MART HAS CENTRAL CERTIFICATION

One of the “Central Certification” groups is K-Mart Management, identified by the Group Number SSK-210.

Their Blue Shield benefits are as follows:

- Basis of — 100% Usual and Customary
- Surgery — wherever performed
- Surgical Assistant
- Anesthesia
- In-hospital medical-care — up to 365 days
- Inpatient — TB, Mental Disorders, Drug Addiction, Alcoholism - 70 days
- Outpatient — Therapeutic Medical Services
- Maternity Services — excludes dependent daughter
- Diagnostic Radiology — inpatient and accidental injury
- Laboratory and Pathology - inpatient and accidental injury
- Outpatient — Diagnostic Radiology, Medical Tests, Laboratory and Pathology
- Radiation Therapy
- Emergency Care
- Inpatient Physical Therapy

# Medicaid-Medicare-Champus Report

## PROPOSED SOLUTIONS FOR MMIS CLAIMS PROCESSING PROBLEMS

ISMS recently conducted a series of workshops designed to assist physicians who are experiencing billing difficulties under IDPA's Medicaid Management Information System (MMIS). These workshops sought to identify major problem areas and clarify confusing aspects of the MMIS program.

At ISMS' urging, IDPA is planning to schedule additional MMIS seminars. This round of IDPA programs will be designed to discuss the entire MMIS billing process and the problems that have been identified with MMIS claims processing. ISMS will monitor the Department's new round of workshops. A seminar schedule is to be forwarded directly to physician offices by the Department.

In addition, ISMS published an *Action Report* article (March 2, 1982) which outlined the most common reasons for MMIS claims to reject, the error message that may appear on the Remittance Advice Sheet, the box number on the claim form that corresponds to the error, and the suggested solutions for avoiding these rejections. Your office staff should use this article as a guide when re-submitting rejected MMIS claims to IDPA for processing. The following is an update on MMIS claims processing problems.

### **PROBLEM: (BOX 24B) — PLACE OF SERVICE.**

Billing for services rendered in a hospital outpatient setting or emergency room.

The use of office visit procedure codes in an outpatient hospital setting will cause claims to reject.

**SOLUTION:** Services rendered in outpatient departments should reflect the CPT IV emergency service codes #90500-90517 - new patient, and #90530-90570 - established patient. A physician who maintains an *office* in a hospital outpatient department and provides medical care to recipients in that office should code Box 24B (Place of Service) as Doctor's Office (3) *not* Outpatient Hospital (2). In addition, if the service is rendered in a hospital outpatient setting, Box 21 of the claim form (name and address of the facility) must be completed. At ISMS' request the Department of Public Aid is reviewing its policy on outpatient services for possible clarification.

### **PROBLEM: (BOX 31) — PHYSICIAN OR SUPPLIER NAME AND ADDRESS.**

Some physicians who practice in a group or clinic have completed Box 31 on the MMIS claim form with the name and address of the group or clinic. This information will cause a claim to reject. The error message that may appear on the Remittance Advice Sheet is "the Provider name does not match the Provider number."

**SOLUTION:** Box 31 should be completed with the name and address of the individual physician who provided the service. IDPA will reimburse monies to the group or clinic if the group is: (A) indicated as a payee option on the Provider Information Sheet; and (B) the physician indicates the appropriate payee option (single digit number) in Box 33 (employer I.D. number) on the MMIS claim form.

### **PROBLEM: (BOX 35 AND BOX 36) — ORIGINAL DOCUMENT CONTROL NUMBER AND ORIGINAL VOUCHER NUMBER.**

Some physicians who rebill IDPA for rejected claims have omitted the DCN number and voucher number from the reconstructed MMIS claim form. This will *not* cause a rejection. The claim will be processed as a new claim. However, resubmitted claims that do not reflect these numbers *may* result in the Department's identifying a physician's corrected billing as a duplicate claim.

**SOLUTION:** When submitting MMIS claims physicians should include the Document Control Number and the Voucher Number on the resubmitted claim. The Document Control Number is located directly above the recipient's name. The original Voucher Number appears in the lower left hand corner on the Remittance Advice Sheet. Once these numbers are provided, the optical scan will refer to the errors noted on the previously submitted claim and complete the processing cycle.

### **PROBLEM: (BOXES 12 AND 13) — HANDWRITTEN INFORMATION**

**SOLUTION:** Recipients are *not* required to sign the MMIS claim form. Only the physician providing the service is required to sign the MMIS claim form.

Handwritten information on the claim will cause an additional two to three weeks in the claim processing cycle.



The ISMS staff has received several requests from physicians who want to change their Provider Information Sheet to reflect a change of address, change of enrollment name, change of payee option, or change of service category. Physicians wishing to change Provider enrollment information should forward a copy of their Provider Information Sheet indicating the appropriate changes or additions to:

**Illinois Department of Public Aid**

**628 East Adams**

**Springfield, Illinois 62763**

**Attention: Ms. Donna Withrow**

Physicians who encounter MMIS billing difficulties should contact their ISMS Field Representative (312-782-1654). Physicians in Chicago may direct routine MMIS inquiries to Christine Szuflita at the Chicago Medical Society Headquarters (670-2550).

## MEDICARE

A recent EDS-Federal Newsletter reported that EDS-Federal would no longer reimburse for hospital stays beyond 24 days, except for certain diagnoses. The maximum length of stay for these diagnoses is 31 days.

In response to ISMS' initiatives, EDS-Federal will print a clarification of that article. EDS-Federal will reimburse for lengths of stay beyond the reported parameters, but the claim must be accompanied by documentation indicating the medical necessity for the continued hospitalization.

In addition, EDS-Federal requires that Medicare, Part B claim forms indicate each *date of service* for hospitalization on the claim.

Finally, EDS-Federal has transferred its claim processing, correspondence and claim review functions to its Marion, Illinois, offices.

A listing of the current EDS offices for physician assistance is provided below.

## Communications With EDS Federal Corporation

### **Claim Submissions**

EDS Federal Corporation  
Post Office Box 4422  
Marion, IL. 62959

### **Claim Development Responses**

EDS Federal Corporation  
Post Office Box 4411  
Marion, IL 62959

### **Claim Form Requests**

EDS Federal Corporation  
999 E. Touhy - Suite 500  
Des Plaines, IL 60018  
Attn: Claim Forms Control  
Des Plaines, IL 60018  
Attn: Claim Forms Control

### **Correspondence & Reviews**

EDS Federal Corporation  
Post Office Box 4433  
Marion, IL 62959

### **Reasonable Charge Profile Requests**

EDS Federal Corporation  
Freedom of Information Request  
Medical Administration  
999 E. Touhy - Suite 500  
Des Plaines, IL 60018

### **Provider Certification Assistance**

EDS Federal Corporation  
Provider Certification Department  
999 E. Touhy - Suite 500  
Des Plaines, IL 60018

### **Administrative Office**

EDS Federal Corporation  
999 E. Touhy - Suite 500  
Des Plaines, IL 60018

### **Telephone Inquiries**

For questions regarding the Medicare Program or a specific claim, call  
Chicago Area: 312/635-6020  
Outside Chicago Area: 800/942-5261 (TOLL FREE)

### **Professional Relations Assistance**

To speak with a member of the Provider Telephone Unit or other member of the Professional Relations staff, please call:  
312/635-6020 — Extension 396  
or, 800/942-5261 (TOLL FREE) — Extension 396

# President's Page



## *The Legislative Process*

Among the most important activities of the Illinois State Medical Society are those concerned with health legislation. During each session of the Illinois General Assembly, between 400 and 500 bills are introduced which in some way affect the health of the citizens of the state. Some of these bills may have direct health implications; others may be relatively peripheral. Some are introduced at the behest of special interest groups; others by legislators with particular interest and/or considerable expertise in health matters. Some of the bills, if enacted, would have generally beneficial effects on the public health; others would not.

Whatever the intentions or motives for introduction of these bills and whatever their effects might be if enacted, all are reviewed by the ISMS Governmental Affairs Council. This important Council is made up of members of the Society who are experienced in legislative affairs. They are supported by staff members who understand the details of laws governing health care delivery in Illinois and are familiar with the political process.

After reviewing proposed legislation, often with input from other Councils or Committees of ISMS, or the affiliate specialty societies, the Council reports recommended positions on each bill to the ISMS Board of Trustees. The Society may opt to support passage of a bill, attempt to defeat it, or simply adopt a neutral stance. The Board reviews these recommendations in light of the directives and policies of the Society as adopted by the House of Delegates and makes a final decision regarding the bill.

Once a position is adopted by the Society, the ISMS legislative staff contacts legislators to implement it. Members of the legislative staff know personally all the key members of both the House and Senate with whom an issue must be discussed before coming to a vote. The staff also uses "Key Man" physicians from around the state to reinforce the ISMS position with the legislators who will be responsible for handling the bill. Key Man physicians are members who are particularly interested in government issues or who are politically involved and have developed a personal relationship with one or more legislators.

Anyone who has visited the Senate or House of Representatives in Springfield cannot but be impressed by the amount of printed material stacked up on each legislator's desk. It is impossible for any legislator to read, let alone become completely familiar with, all this material. As a result, legislators frequently rely on not only their legislative aides but also on lobbyists for their information. In order to be effective, a good lobbyist must not only have intimate knowledge of the field he covers, but also be familiar with the details of the bills under consideration and their potential effects. The background information which he provides legislators must be accurate and not slanted to deceive them. Only in this way can mutual confidence be established.

ISMS can be proud that its lobbyists enjoy a reputation with the members of the Illinois Assembly as knowledgeable and reliable sources of information on all matters affecting the health of the citizens of our state. As a result, legislation is seldom passed which is opposed by the Illinois State Medical Society, unless it is acceptably amended. The important thing is that physicians' interests are well represented in Springfield. The Society has developed the ability to be heard in the legislative process, and it has been proven during every session of the legislature that we physicians, working through the Society, can make an important contribution to good health care legislation in Illinois.

*C. C. Wiggishoff M.D.*

Cyril C. Wiggishoff, M.D., President



One of nature's  
most predictable modalities...



*Alopex lagopus*

## THE ARCTIC FOX

The arctic fox is nature's turncoat. This small, curious animal, only about 2 feet long, lives on the barren tundra above the northern boundaries of tree growth.

Because it neither migrates nor hibernates during the winter months, it is equipped with a very special kind of "reversible coat" that permits year-round habitation.

Like clockwork, the fox's gray-brown fur turns completely white as the winter solstice approaches, and then returns to its normal color during the spring thaw. The fox's coat also undergoes a smoky blue phase. This cyclical camouflage enables the fox to blend readily with the changing scenery of its environment, masking it from predators and prey.

The arctic fox: an animal whose coat is always in season. Few animals in nature have such a predictable pattern of adaptability.

In medicine, few drugs can match the predictable pattern of therapeutic action that you can expect with Librium. Well known for its safety, Librium provides prompt, effective relief of anxiety disorders and symptoms. At recommended doses it has virtually no effect on either the cardiovascular or the respiratory system, and rarely affects mental acuity. As with any drug in its class, patients should be cautioned about driving, operating hazardous machinery or drinking alcohol while on Librium therapy.

Librium. A natural selection for your clinically anxious patients.



For the treatment of anxiety

5 mg, 10 mg, 25 mg capsules

# Librium®

chlordiazepoxide HCl/Roche

## one of man's



**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Known hypersensitivity to drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety disorders and symptoms, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl/Roche) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50. Libritabs® (chlordiazepoxide/Roche) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

## Clinics for Crippled Children Listed for June

Thirty-five clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 22 general clinics, 10 cardiac clinics, one for children with neurological problems, and 2 for children with myelodysplasia. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- 1 Maryville - Oliver C. Anderson Hospital
- 1 Wheaton - Marianjoy Rehabilitation Hospital
- 1 Park Ridge General - PM - Lutheran General Hospital
- 1 Park Ridge Cardiac - AM - Lutheran General Hospital
- 2 Carmi - Carmi Township Hospital
- 3 Lake County Cardiac - Victory Memorial Hosp.
- 3 Hinsdale - Hinsdale Sanitarium
- 4 Division Cardiac - U. of I. at the Medical Center
- 7 Peoria Myelodysplasia - St. Francis Medical Center
- 8 East St. Louis - Community Hospital
- 8 Peoria General - St. Francis Medical Center
- 9 Joliet - St. Joseph's Hospital
- 9 Chicago Heights General - St. James Hospital
- 9 Champaign-Urbana - McKinley Health Service Center
- 10 West Frankfort - United Mine Worker's of America - Union Hospital
- 10 Rockford - St. Anthony Hospital
- 10 Aurora Cardiac - Mercy Center for Health Care Services
- 10 Kankakee General - St. Mary's Hospital
- 14 Belleville - Belleville Memorial Hospital
- 14 Peoria Cardiac - St. Francis Medical Center
- 14 Chicago Heights Cardiac - St. James Hosp.
- 14 Maywood - (Ortho/Ped/Neuro) - Loyola Medical Center
- 15 Rock Island General - Moline Public Hosp.
- 15 Decatur - Decatur Memorial Hospital
- 16 Springfield Ped-Neuro - Memorial Medical Bldg.
- 17 Bloomington (no Peds) - Mennonite Hospital
- 17 Elmhurst Cardiac - Mercy Center for Health Care Services
- 18 Kankakee Cardiac - St. Mary's Hospital
- 21 Maywood (Ortho/Ped) - Loyola Medical Center
- 23 Elgin MM - Sherman Hospital
- 23 Chicago Heights General - St. James Hospital
- 24 Anna - Anna Mental Health and Developmental Center
- 24 Champaign Children's Home - Champaign
- 28 Peoria Cardiac - St. Francis Medical Center
- 28 Chicago Heights Cardiac - St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



Roche Products Inc.  
Manati, Puerto Rico 00701

# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This month's Viewbox was contributed by Richard Marsan, M.D., associate professor of radiology, Loyola University/Stritch School of Medicine, Maywood.*



*This 65-year-old patient experienced a transient ischemic attack one week prior to admission. On physical examination a bruit was heard on the right side of the neck. Figure 1 illustrates one of the non-invasive vascular studies which were done (Doppler ultrasound). A stenosis of the internal carotid artery is demonstrated. What study would you do next?*

- (a) Selective Carotid Angiogram
- (b) Digital Subtraction Angiogram
- (c) Aortic Arch Angiogram
- (d) Intravenous Angiogram
- (e) Computed Tomography

**Figure 1**

*(Continued on page 348)*



# ***HYPERTENSION:***



# METHYLDOPA? RESERPINE? INDERAL? COUNTLESS

# THOUSANDS WOULD BE BETTER OFF WITH

# INDERAL<sup>®</sup>

## (PROPRANOLOL HCl) B.I.D.

### The sooner, the better.

Today, INDERAL—instead of methyldopa, instead of reserpine.

INDERAL exhibits few of the disturbing side effects of methyldopa and reserpine. Sedation, depression, and impotence are rare\*. Tolerance is not likely to occur, as it frequently does with methyldopa. For the vast majority of patients—INDERAL means a step toward improving the quality of life. (INDERAL should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.)\*

INDERAL blocks beta-receptor sites *in the heart* to reduce heart rate and cardiac output—reducing cardiac work load—sparing an overburdened heart.

Hypertensive hearts can rest easy with INDERAL. For many—it is ideal, first-step therapy.

INDERAL—the sooner, the better for hypertension—a leading risk factor in coronary heart disease.<sup>1</sup>

\*Please see following page for Brief Summary of Prescribing Information.





# THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD

## INDERAL® (PROPRANOLOL HCl) B.I.D. FOR HYPERTENSION

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)  
INDERAL® BRAND OF propranolol hydrochloride A beta-adrenergic blocking agent

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

### CONTRAINDICATIONS

INDERAL is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

### WARNINGS

**CARDIAC FAILURE.** Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

**IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE.** continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn. b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

**IN PATIENTS WITH ANGINA PECTORIS.** there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

**IN PATIENTS WITH THYROTOXICOSIS,** possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

**IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME,** several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

**IN PATIENTS DURING ANESTHESIA** with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

**IN PATIENTS UNDERGOING MAJOR SURGERY,** beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

**IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM** (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA.** Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**USE IN PREGNANCY.** The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

### PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be served at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

### ADVERSE REACTIONS

**Cardiovascular:** bradycardia, congestive heart failure, intensification of AV block; hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytic purpura.

**Central Nervous System:** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

**Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with acid and sore throat, laryngospasm and respiratory distress.

**Respiratory:** bronchospasm.

**Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

### ORAL

#### DOSAGE AND ADMINISTRATION

**HYPERTENSION.** Dosage must be individualized. The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg/day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

#### PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

#### INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

#### OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

**BRADYCARDIA:** ADMINISTER ATROPINE (0.25 to 1.0 mg). IF THERE IS NO RESPONSE TO VAGAL BLOCKADE, ADMINISTER ISOPROTERENOL CAUTIOUSLY.

**CARDIAC FAILURE:** DIGITALIZATION AND DIURETICS.

**HYPOTENSION:** VASOPRESSORS, e.g., LEVATERENOL OR EPINEPHRINE (THE EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

**BRONCHOSPASM:** ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

#### HOW SUPPLIED

INDERAL (propranolol hydrochloride)

**TABLETS**  
No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

#### INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10.

Reference: 1. Freis, E. D. Hypertension (Suppl. II) 3:230 (Nov.-Dec.) 1981.

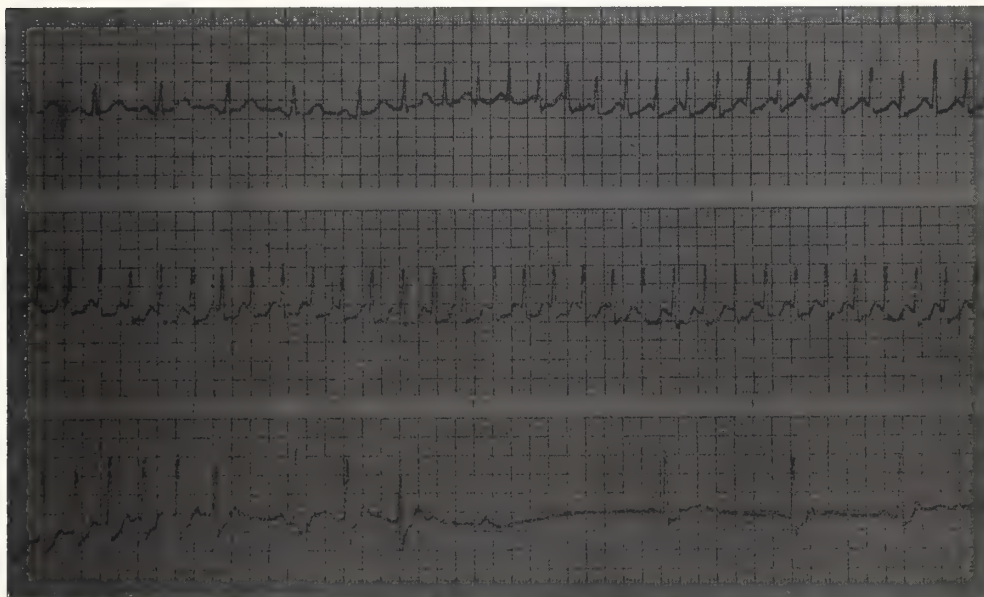
7997/

**Ayerst** AYERST LABORATORIES  
New York, N. Y. 10017

# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a sixty-four year old man with a history of palpitations since childhood. These could be stopped by lying on his left side, by deep breathing, or by the Valsalva maneuver. In the past six months, the palpitations had become worse. He had more attacks and they were often associated with a feeling of faintness and a chest ache that radiated to his left upper arm. His past history included treated hypertension for several years. His physical examination was normal. A chest X-ray and twelve lead ECG were normal. A Bruce protocol multistage exercise electrocardiogram was normal with a maximal heart rate of 170 beats/minute, a maximal blood pressure of 225/135mmHg, and a 5.7 minute duration of exercise. He stopped exercise because of dyspnea. A twenty-four hour ambulatory ECG was ordered. This ECG strip was recorded when the patient had a mild spell of palpitations.*



## Questions:

1. The ECG rhythm strip shows:
  - A. Paroxysmal supraventricular tachycardia.
  - B. Paroxysmal ventricular tachycardia.
  - C. Cycle dependent bundle branch block.
  - D. Episodic sinus tachycardia.
  - E. None of the above.
2. Successful treatment for this cardiac arrhythmia could include:
  - A. Digoxin.
  - B. Verapamil.
  - C. Beta-blocking drugs such as propranolol.
  - D. Carotid sinus massage.
  - E. All of the above.

(Continued on page 365)



**BECAUSE  
A THIAZIDE ALONE  
CAN ONLY DO  
SO MUCH...**

**AND YET  
CAN DO  
TOO MUCH.**



# INCREASE CONTROL WITHOUT INCREASING POTASSIUM PROBLEMS.

## **A dependable means to long-term blood pressure control.**


Many times, a diuretic alone can't keep hypertension in check. *INDERIDE*, however, can pick up where thiazide therapy leaves off.

The combination of propranolol HCl, the world's most trusted beta blocker, and hydrochlorothiazide, the standard among diuretics, enables *INDERIDE* to exert an additive antihypertensive effect.<sup>1,2</sup> In fact, a propranolol/hydrochlorothiazide regimen maintained blood pressure below 90 mm Hg in 81.8% to 86.4% of patients followed for 6 to 18 months of therapy.<sup>1</sup>

## **Low thiazide dosage means reduced risk of hypokalemia.**

When thiazides are prescribed in doses greater than 50 mg/day, the potential for hypokalemia increases substantially. What's more, the greater the fall in serum  $K^+$ , the greater the risk of hypokalemia-induced PVCs.<sup>3,4</sup>

With *INDERIDE*, the additive hypotensive effect of propranolol HCl allows the effective dose of hydrochlorothiazide to be kept low (25 mg b.i.d.). And by lowering the daily dose of diuretic, *INDERIDE* also lowers the potential for diuretic-induced side effects. Potassium problems are less likely to occur—yet blood pressure can be controlled consistently.



# **INDERIDE<sup>®</sup>**

Each tablet contains *INDERAL*<sup>®</sup> (propranolol HCl) 40 mg or 80 mg, and hydrochlorothiazide 25 mg | **B.I.D. 40/25  
80/25**

## **When you know you need more than a thiazide.**

Please see Brief Summary of Prescribing Information on following page.



# BRIEF SUMMARY

(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

**INDERIDE®**  
BRAND OF  
propranolol hydrochloride  
(INDERAL®)  
and hydrochlorothiazide

No. 474—Each IINDERIDE®-40/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	.40 mg
Hydrochlorothiazide	25 mg
No. 476—Each IINDERIDE®-80/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	.80 mg
Hydrochlorothiazide	25 mg

**WARNING:** This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

**DESCRIPTION:** IINDERIDE combines two antihypertensive agents: IINDERAL (propranolol hydrochloride), a beta-adrenergic blocking agent, and hydrochlorothiazide, a thiazide diuretic-antihypertensive.

**INDICATION:** IINDERIDE is indicated in the management of hypertension. (See boxed warning.)

**CONTRAINDICATIONS:** Propranolol hydrochloride (INDERAL®): Propranolol hydrochloride is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

**Hydrochlorothiazide:** Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

**WARNINGS: Propranolol hydrochloride (INDERAL®):** CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn; b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in re-starting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA:** Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

**USE IN PREGNANCY: Propranolol hydrochloride (INDERAL®):** The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

**Hydrochlorothiazide:** Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**Nursing Mothers:** Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

**PRECAUTIONS: Propranolol hydrochloride (INDERAL®):** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

**Hydrochlorothiazide:** Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake may also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

**ADVERSE REACTIONS: Propranolol hydrochloride (INDERAL®):** Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

**Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

**Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

**Respiratory:** bronchospasm.

**Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**Hydrochlorothiazide:** Gastrointestinal: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, saladenitis.

**Central Nervous System:** dizziness, vertigo, paresthesias, headache, xanthopsia.

**Hematologic:** leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

**Cardiovascular:** orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

**Hypersensitivity:** purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

**Other:** hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

**DOSAGE AND ADMINISTRATION:** The dosage must be determined by individual titration (see boxed warning).

Hydrochlorothiazide is usually given at a dose of 50 to 100 mg per day. The initial dose of propranolol is 40 mg twice daily and it may be increased gradually until optimum blood pressure control is achieved. The usual effective dose is 160 to 480 mg per day.

One to two IINDERIDE tablets twice daily can be used to administer up to 320 mg of propranolol and 100 mg of hydrochlorothiazide. For doses of propranolol greater than 320 mg, the combination products are not appropriate because their use would lead to an excessive dose of the thiazide component.

When necessary, another antihypertensive agent may be added gradually beginning with 50 percent of the usual recommended starting dose to avoid an excessive fall in blood pressure.

**OVERDOSE OR EXAGGERATED RESPONSE:** The propranolol hydrochloride (INDERAL) component may cause bradycardia, cardiac failure, hypotension, or bronchospasm.

The hydrochlorothiazide component can be expected to cause diuresis. Lethargy of varying degree may appear and may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function, and in the absence of significant serum electrolyte changes or dehydration. The mechanism of central nervous system depression with thiazide overdosage is unknown. Gastrointestinal irritation and hypermotility can occur; temporary elevation of BUN has been reported, and serum electrolyte changes could occur, especially in patients with impairment of renal function.

**TREATMENT:** The following measures should be employed: GENERAL—If ingestion is, or may have been, recent, evacuate gastric contents taking care to prevent pulmonary aspiration. BRADYCARDIA—Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. CARDIAC FAILURE—Digitalization and diuretics. HYPOTENSION—Vasopressors, e.g., levaterenol or epinephrine. BRONCHOSPASM—Administer isoproterenol and aminophylline. STUPOR OR COMA—Administer supportive therapy as clinically warranted. GASTROINTESTINAL EFFECTS—Though usually of short duration, these may require symptomatic treatment. ABNORMALITIES IN BUN AND/OR SERUM ELECTROLYTES—Monitor serum electrolyte levels and renal function; institute supportive measures as required individually to maintain hydration, electrolyte balance, respiration, and cardiovascular-renal function.

**HOW SUPPLIED:** No. 474—Each IINDERIDE®-40/25 tablet contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 476—Each IINDERIDE®-80/25 tablet contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

**References:** 1. Veterans Administration Cooperative Study Group on Antihypertensive Agents: J.A.M.A. 237:2303 (May 23) 1977. 2. Bravo, E.L., Tarazi, R.C., and Dustan, H.P.: N. Engl. J. Med. 292:66 (Jan. 9) 1975. 3. Hollifield, J.W., and Slaton, P.E.: Acta Med. Scand. [Suppl.] 647:67 1981. 4. Holland, O.B., Nixon, J.V., and Kunnert, L.: Am. J. Med. 70:762 (Apr.) 1981.

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# Pulse of the ISMS Auxiliary

## Capture The Spirit Of Auxiliary

BY MRS. DON HINDERLITER, ISMSA PRESIDENT

*This month's column is excerpted from Mrs. Hinderliter's inaugural address during the ISMSA Annual Meeting in April.*

This, the fifty-fourth annual meeting of the Illinois State Medical Society Auxiliary, is a prelude to a new beginning. Times in our society are full of stress, uncertainty, and change. As auxiliary members, we are called upon, more than ever, to be not only pillars of strength, but also agents of action.

Through the past few years in ISMSA, we have looked at ourselves, taken one step at a time, and walked down the yellow brick road. We achieved much in the past but more is needed for the future. I strongly feel it is time for us to move forward into the 80s with a positive attitude. As your new president, I'm asking each of you, now, to capture the spirit of auxiliary and spread its message.

ISMSA is involved in nearly all phases of American life, including child safety, legislation, promotion of wellness, education and research. With these important foci in our organization we can only grow stronger.

Auxilians are tremendously active today. We are returning to careers, we are going back to school, and we are generally in the mainstream. These are good reasons to remain involved in the Illinois State Society Auxiliary, not excuses for discontinuing membership. Our programs offer something for everyone. We are limited only by imagination and creativity.

This year, one important aspect of my term will be strong involvement in legislation. People are turning away from governmental paternalism to individual responsibility. As President Reagan has said, this is an era where we are once again proud to be Americans. As auxiliaries involved in legislation, we can help maintain the momentum.

Counties will play an important role this year.

Our members may choose to become involved in campaigns of candidates whose views are favorable to medicine. We can have an impact upon legislation.

I will need your support this year. Together we can capture the spirit of auxiliary and move forward with a positive image for medicine.

Contemporary woman is changing, and if ISMSA is to remain viable we must meet the needs of all our members, not just a select few. Through our programs and projects we offer service that no other organization can. That is something to be proud of! The federal budget cuts to social service will make our organization even more important. Emerson once said, "Concern is often the seed for action." Concerned auxiliaries will be called upon to fill the gaps resulting from those cut-backs.

By working together closely, we can enhance the strength of AMA-ERF, the Resident Physician/Medical Student Spouse program, Health Awareness, and Shape Up For Life.

This year four new programs will be introduced. They are: Grief and Bereavement, Awareness of the Fetal Alcohol Syndrome, Learning to Adapt to Life in Private Practice as a Spouse, and New Members Club.

I would like you to ask yourself, "how can I be a part of this auxiliary?" Consider your interests, consider your abilities. ISMSA needs each of you to take an active role.

Opportunities in the auxiliary are as varied as your interests, so let me ask you to capture the spirit of auxiliary with me and together let's move forward as we focus on the 80s. ◀



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Bioavailability findings\* of Oral, Sublingual and Chewable Cardilate® dosage forms in volunteers demonstrated that the Oral (swallowed) 10mg Tablet provided a 6-hour duration of pharmacologic effect; more than 3 times longer than when given sublingually, or as the chewable Tablet. Cardilate Oral Tablets are recommended for the prophylaxis and long-term treatment of patients with frequent or

recurrent anginal pain and reduced exercise tolerance associated with angina pectoris.

\*Hannemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. C., Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. R.: Digital Plethysmography For Assessing Erythrityl Tetranitrate Bioavailability. Clin Pharmacol and Ther 29:35-39, 1981.

**Cardilate®**  
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#### **CARDILATE® (ERYTHRITYL TETRANITRATE)**

**INDICATIONS:** Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris rather than for the treatment of the acute attack of angina pectoris since its onset is somewhat slower than that of nitroglycerin.

**CONTRAINDICATIONS:** Idiosyncrasy to this drug.

**WARNING:** Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

**PRECAUTIONS:** Intraocular pressure is increased therefore caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.

**ADVERSE REACTIONS:** Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine and many other agents. An occasional individ-

ual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and / or exfoliative dermatitis may occasionally occur.

#### **DOSAGE AND ADMINISTRATION**

Oral / Sublingual Tablets: Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg. prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

#### **HOW SUPPLIED:**

**CARDILATE** (Erythrityl Tetranitrate) TABLETS (Scored)  
for ORAL or SUBLINGUAL USE 5 mg: Bottle of 100;  
10 mg: Bottles of 100 and 1000; 15 mg: Bottle of 100

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# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**BENTON:** Family Physician wanted to join growing medical staff associated with a modern, 113-bed community hospital in southern Illinois. Guarantee and other benefits. Excellent recreational and university facilities nearby. **CONTACT:** Ann Acton, Franklin Hospital, Benton, 62812, (618) 439-3161, Ext. 367/368. (4)

**CARBONDALE:** Family or General Practice. Community Health Center in southern Illinois, 10 miles from SIU-Carbondale. Affiliation with Black Lung Clinic Programs possible. Established practice with multi-disciplinary staff. Position available immediately. Salary, fringe benefits are very competitive; malpractice insurance and vacation also provided. **CONTACT:** George M. O'Neill, Shawnee Health Service & Development Corporation, 103 S. Washington, #210, Carbondale 62901 (618-457-3351). (4)

**CENTRAL ILLINOIS:** Two community hospitals within twenty minutes of each other are currently seeking a urologist. Possible partnership with consulting urologist now servicing this area. More patients than one urologist can handle. Area is known for recreational activities. **Contact:** Search Committee, P.O. Box 430, Pana, 62557. (217-562-2131 x271) (4)

**CLIFTON:** Service Area, 8,500—Immediate opening for family practitioner in rural setting. First year: guarantee, office space/staffing provided. Seventy miles south of Chicago on interstate highway. Excellent school system. Obstetrics or general internal medicine background helpful. **CONTACT:** George Rasmussen, Central Community Hospital, Clifton 60927. AC 815-694-2392. (10)

**FAIRBURY:** Family practice physician—Excellent opportunity to join General Practice Physician planning retirement in two years. Cross coverage is available in this thriving rural practice. Fairbury Hospital, a 112-bed JCAH accredited hospital, offers income guarantees and other financial assistance. **Contact:** Kate H. Dickey, Director, Physician Recruitment, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739. (815-692-2346 x215) (4)

**GALESBURG:** Population 35,305. Seat of Knox County, pop. 61,300. An attractive college community 180 miles from Chicago. Near Peoria, Quad-Cities. Diversified industry and agri-

business. Full selection of educational, cultural and recreational activities. For information on practice opportunities, **CONTACT:** David D. Fleming, Vice-President, Galesburg Cottage Hospital, 695 N. Kellogg St., Galesburg 61401. 309/343-8131. (4)

**KEWANEE:** 108 bed community hospital involved in an expansion program is interested in recruiting family practitioners to our service area of 35,000 population. Several practice opportunities exist in group or solo practices. The population centers in the service area range from 15,000 in population and less. **Contact** Harold L. Bischoff, Kewanee Public Hospital, 719 Elliott Street, Kewanee 61443 (309) 853-3361. (4)

**LINCOLN:** 20 miles from Southern Illinois University School of Medicine in Springfield and halfway between St. Louis and Chicago on I55. Need two family practice physicians for growing practice. Office facilities available with 10 man medical group. **Contact** Mary Richter, 311 Eighth, Lincoln 62656. (217/732-9681). (4)

**MARSHALL:** Population 4,000. County seat of Clark County. Rural community. Comparatively new medical center with available space for 4 doctors. Presently have 2 doctors. Facility fully equipped with lab, x-ray, therapy, emergency room, pharmacy. Located 17 miles from three major hospitals. Have excellent school system and recreational facilities. **CONTACT:** Donald B. Smitley, Admin., 410 N. 2nd St., P.O. Box 219, Marshall 62441, 217-826-2358. (4)

**SULLIVAN:** Population 5,000. New medical center with complete office and ancillary services available. Near universities and colleges. All recreational facilities nearby. **CONTACT:** Sandra Elder, 2 W. Adams, Sullivan 61951 (217) 728-8316 or (217) 728-4186. (4)

**WATSEKA:** Population service area 35,000. Opening for orthopedic surgeon. 23 physicians on staff at present. 85 miles from Chicago in rural area, 160 bed hospital. Within one hour drive of major universities. Very liberal financial package available first year. **Contact** Paul F. Wenz, 200 Fairman Street, Watseka 60970. (815) 432-5201. (4)

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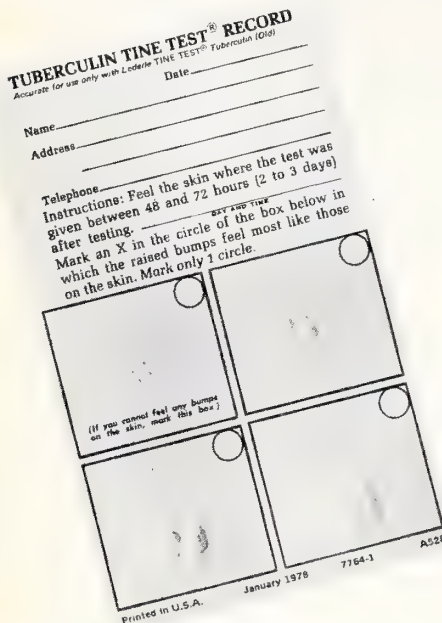


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**Indications:** For screening for tuberculosis.

**Precautions:** Use with caution in persons with acute tuberculosis (activation of quiescent lesions is rare); and in patients with known allergy to acacia. Reactivity to the test may be suppressed in those receiving corticosteroids or immunosuppressive agents, or those who have recently been vaccinated with live virus vaccine such as measles, mumps, rubella, polio, etc. With a positive reaction, further diagnostic procedures must be considered, i.e., chest x-ray, microbiologic examinations of sputum and other specimens, confirmation of positive tine test (except vesiculation reactions) by Mantoux method. When vesiculation occurs, the reaction is to be interpreted as strongly positive and a repeat test by the Mantoux method must not be attempted. If a patient has a history of occurrence of vesiculation and necrosis with a previous tuberculin test by any method, tuberculin testing should be avoided. Similar or more severe vesiculation with or without necrosis is likely to occur.

Pregnancy Category C. Animal reproduction studies have not been conducted; whether Tuberculin, Old, TINE TEST® can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity is unknown. Tuberculin, Old, TINE TEST should be given to a pregnant woman only if clearly needed. During pregnancy, known positive reactors may demonstrate a negative response.

**Adverse Reactions:** Vesiculation, ulceration, or necrosis may appear at test site in highly sensitive persons. Pain, pruritus and discomfort at test site may be relieved by cold packs or by topical glucocorticoid ointment or cream. Any transient bleeding at puncture site is not significant.



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## "I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

June 7	Grant Hospital	Chicago
June 7	Hinsdale Sanitarium & Hosp. & A.C.S.	Hinsdale
June 14	Christ Hosp. & A.C.S.	Oak Lawn
June 14	Evanston Hospital & A.C.S.	Evanston
June 14	Lutheran General Hospital	Park Ridge
June 16	A.C.S. Moderators' Training	Chicago
July 12	Anchor & A.C.S.	Chicago
July 26	Condell Mem. Hosp. & A.C.S.	Libertyville
August 16	Lutheran General Hospital	Park Ridge
August 23	Christ Hospital & A.C.S.	Oak Lawn
August 30	Anchor & A.C.S.	Chicago
Sept. 14	St. Francis Hosp. & A.C.S.	Blue Island
Sept. 20	Condell Memorial Hosp. & A.C.S.	Libertyville
October 4	Alexian Bros. Med. Centr.	Oak Forest
October 11	Anchor & A.C.S.	Chicago

# Medical Student Section in Action

## ISMS Council On Education and Manpower

The ISMS Council on Education and Manpower has been studying and discussing several issues of importance to Illinois physicians and Illinois medical students. The issues fall into two general categories, those which concern the education of students and physicians, and those which concern the manpower distribution and manpower need within the state.

One issue of concern to medical students is whether graduates of Illinois medical schools should be obligated to return service to Illinois. No formal policy has been reached at this point, but the issue has stimulated much discussion. In one sense, if state support to medical schools is meant to affect the manpower distribution and manpower needs within our state, then it seems appropriate for Illinois taxpayers to expect a "return on their investment." Alternatively, if state support is meant to aid Illinois students in their education, then a service obligation is not as pertinent. Tax dollars in the latter case are not as much an investment as a service to the students of Illinois.

Another issue of Council discussion has been the changing role of the physician in today's health care system. A symposium entitled, "COMPREHENSIVE CARE—WHO DOES WHAT?—BEST?" has been planned to address this question. At this writing, the symposium is expected to include participation of many of the allied health professions. The symposium will seek to better define the present roles of the different groups providing health care today. It is hoped that with better definitions and better communication, the individual health groups would be able to work together in a more coordinated fashion toward providing the best possible care for the consumer.

The need for such a symposium raises interesting questions about the changing role of the physician in the health care system. There are presently 140 allied health occupation categories in Illinois today, a realization that is overwhelming. Growth in the allied health fields took place for the most part during the last two decades. It is likely that it took place as a result of a relative physician shortage and a natural relegation of certain duties from an over-occupied physician

to a non-physician health care provider. In retrospect it is doubtful that physicians appreciated the full impact of relinquishing those duties to non-physicians, however necessary it was. We find ourselves now in a situation where the physician is becoming less and less responsible for those duties, relegated or not. The natural concern is that patient care has become less cohesive, more expensive, and less responsive to patient needs.

The ability of the physician to control the use of ancillary services within a hospital or the use of allied health professionals is becoming more difficult. Several of these fields are, of course, independent and are used without physician participation. Still, even those based solely within the hospital setting have become difficult to control as the hospital has emerged as a growing power, separate from its attending staff. Despite many changes in the delivery of health care over the last 20 years, most patients view the role of the physician as central to their care, regardless of the constraints of hospital protocol.

Specialization within the medical profession has also threatened the control physicians have over patient care. It has become obvious that there is not always one physician providing continuity of care, and that many patients have stumbled with "symptoms in hand" from specialist to specialist. There has not always been a physician looking at the "big picture," acting as an interpreter as each new test is performed, and helping the patient decide which service is really necessary and which is not. As medical care has become progressively fragmented, an opportunity has been provided for a more centralized non-physician decision making body to gain control. To a large extent it appears that this fragmentation of service has created the void which the 140 other health related occupations now fill. The important question is whether patient care in general has suffered. It must be stressed to physicians in training that specialization should not negate or preclude the practice of good primary care medicine, and does not relieve the physician of responsibility for the patient's total care.

Jerome Hines  
Council on Education and Manpower



## Obituaries

**Anderson, Eugene W.**, LaGrange, died January 13, 1982 at the age of 79. Dr. Anderson was a graduate of the Kriskville College of Osteopathy and Surgery, Missouri.

**\*\*Berens, David G.**, Chicago, died March 19, 1982 at the age of 85. Dr. Berens was a 1919 graduate of the Loyola University Stritch School of Medicine.

**\*\*Biggs, Alfred D.**, Sun City, Arizona, died February 18, 1982 at the age of 88. Dr. Biggs was a 1922 graduate of Rush Medical College.

**Boswell, Paul P.**, Chicago, died March 3, 1982 at the age of 76. Dr. Boswell was a 1939 graduate of the University of Minnesota Medical School.

**\*\*Clavert, Robert M.**, a member of the 50 year Club, passed away at Michael Reese Hospital, Chicago at the age of 97 due to coronary infarction. He was a graduate of Meharry Medical College School of Medicine, Nashville, Tennessee.

**\*Campione, Kenneth M.**, Chicago, died February 25, 1982 at the age of 58. Dr. Campione was a 1947 graduate of the University of Chicago Pritzker School of Medicine.

**Casciato, Nicholas**, Oak Park, died January 29, 1982 at the age of 79. Dr. Casciato was a 1931 graduate of the Loyola University Stritch School of Medicine.

**\*\*Cornblett, Theodore**, Chicago, died March 25, 1982 at the age of 83. Dr. Cornblett was a 1923 graduate of the St. Louis University School of Medicine.

**\*Dibble, Howard M.**, Chicago, died March 6, 1982 at the age of 64. Dr. Dibble was a 1942 graduate of the University of Chicago Pritzker School of Medicine.

**\*Dippold, Anton**, Mattoon, died March 6, 1982 at the age of 57. Dr. Dippold was a 1951 graduate of *Medizinsche Fakultat de Universitat Graz*, Austria.

**\*Dobin, Norman B.**, Chicago, died February 15, 1982 at the age of 70. Dr. Dobin was a 1936 graduate of the University of Illinois College of Medicine.

**\*Flaxman, Abraham J.**, Chicago, died March 19, 1982 at the age of 71. Dr. Flaxman was a 1941 graduate of *Faculte de Meddcine de l'Universit* *de Lausanne*, Switzerland.

**Fishman, Howard C.**, Northbrook, died March 7, 1982 at the age of 49. Dr. Fishman was a staff member at Grant Hospital and assistant chief of medical services at Hines Veterans Administration Hospital.

**\*\*Gearhardt, Dwight I.**, Barrington, died March 27, 1982 at the age of 81. Dr. Gearhardt was a 1925 graduate of the University of Iowa College of Medicine.

**\*\*Hall, William L.**, Greenville, died January 23, 1982 at the age of 91. Dr. Hall was a 1915 graduate of the St. Louis University School of Medicine.

**\*\*Heinemeyer, Floyd L.**, Rockford, died February 9, 1982 at the age of 84. Dr. Heinemeyer was a 1924 graduate of Northwestern University Medical School, Chicago.

**\*\*Hill, Tolbert F.**, Athens, died January 28, 1982 at the age of 107. Dr. Hill, believed to be the oldest physician in Illinois, was an 1896 graduate of Rush Medical College. The second of four generations of physicians, Dr. Hill opened his first office in Athens in 1898 and received a pin in 1978 from the ISMS 50-Year Club for 80 years of medical practice.

**\*\*Hirsch, Franz E.**, Chicago, died February 2, 1982 at the age of 84. Dr. Hirsch was a 1927 graduate of the *Fredrich-Wilhelms Universitat Medizinische Fakultat*, Berlin, Prussia.

**\*Hirsch, Marvin M.**, Chicago, died March 10, 1982 at the age of 65. Dr. Hirsch was a 1950 graduate of the University of Illinois College of Medicine.

**\*Jesser, Joseph H.**, Chicago, died November 3, 1981 at the age of 74. Dr. Jesser was a 1933 graduate of Loyola University Stritch School of Medicine.

**Lohmann, Carl J.**, Burlington, died December 23, 1981 at the age of 81. Dr. Lohmann was a 1925 graduate of the University of Iowa School of Medicine.

**\*Lowe, Robert J.**, Chicago, died February 10, 1982 at the age of 40. Dr. Lowe was a 1968 graduate of Loyola University Stritch School of Medicine.

**\*Markoutsas, George C.**, Chicago, died January 24 at the age of 71. Dr. Markoutsas was a 1941 graduate of the University of Health Sciences/Chicago Medical School.

**\*Mohr, Dorothy P.**, Chicago, died January 26, 1982 at the age of 46. Dr. Mohr was a 1961 graduate of the University of Illinois College of Medicine.

**\*\*Montgomery, Nolan G.**, Mesa, died January 1, 1982 at the age of 87. Dr. Montgomery was a 1926 graduate of Indiana University School of Medicine.

**\*Mueller, Clarence J.**, Sterling, died February 14, 1982 at the age of 71. Dr. Mueller was a 1943 graduate of New York Medical College.

**Nieman, Aaron**, Clearwater, Florida, formerly of Chicago, died March 26, 1982 at the age of 84.

**\*Nordland, James J.**, Joliet, died March 30, 1982 at the age of 53. Dr. Nordland was a 1951 graduate of Northwestern University Medical School.

**\*\*Olson, Ernest C.**, Chicago, died January 25, 1982 at the age of 84. Dr. Olson was a 1924 graduate of Rush Medical College.

**\*Pollard, Vincent D.**, Winnetka, died January 14, 1982 at the age of 66. Dr. Pollard was a 1943 graduate of the Loyola University Stritch School of Medicine.

**\*\*Reis, Joseph H.**, Lombard, died January 25, 1982 at the age of 82. Dr. Reis was a 1925 graduate of the Loyola University Stritch School of Medicine.

**\*\*Stanka, Hugo**, Boca Raton, Florida, died January 9, 1982 at the age of 81. Dr. Stanka was a 1927 graduate of *Medizinsche Fakultat de Universitat Wien*, Germany.

**Starr, Merritt P.**, Claremont, California, died February 5, 1982 at the age of 88. Dr. Starr was a 1921 graduate of Rush Medical College.

**Steck, Robert C.**, Anna, died January 31, 1982 at the age of 72. Dr. Steck was a graduate of both the University of Illinois Medical School and the University of Illinois School of Pharmacy.

**Tierney, Thomas M.**, Oak Park, died February 27, 1982 at the age of 68.

**\*\*Twohey, Frances P.**, Urbana, died March 1, 1982 at the age of 76. Dr. Twohey was a 1931 graduate of the University of Illinois College of Medicine.

**\*\*Van Epps, James**, Hinsdale, died October 11, 1981 at the age of 81. Dr. Van Epps was a 1928 graduate of the Loyola University Stritch School of Medicine.

**Wagner, Merrill W.**, Wonder Lake, died January 25, 1982 at the age of 63. Dr. Wagner was a 1938 graduate of the University of Illinois College of Medicine.

**Weinberg, Jack**, Glencoe, died March 1, 1982 at the age of 72. Dr. Weinberg was director of the Illinois State Psychiatric Institute and a former president of the American Psychiatric Association.

**Wolfe, Albyn G.**, Jacksonville, died February 19, 1982 at the age of 76. Dr. Wolfe was a graduate of the University of Illinois College of Medicine.

*\*Indicates ISMS Member*

*\*\*Indicates Member of ISMS Fifty Year Club*

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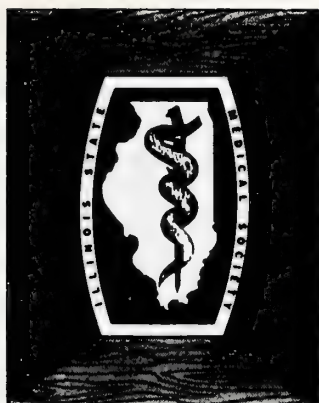
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# I M J

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## *Three Case Reports*

# Mucoepidermoid Tumors of the Bronchus

BY B. D. LIFSCHULTZ, M.D., R. VANECKO, M.D.  
and D.F. HIDVEGI, M.D./CHICAGO

*Three cases of pulmonary mucoepidermoid carcinoma are presented with review of the literature. This bronchial tumor can be highly malignant. However, surgery may be curative, especially when the primary is small and detected early.*

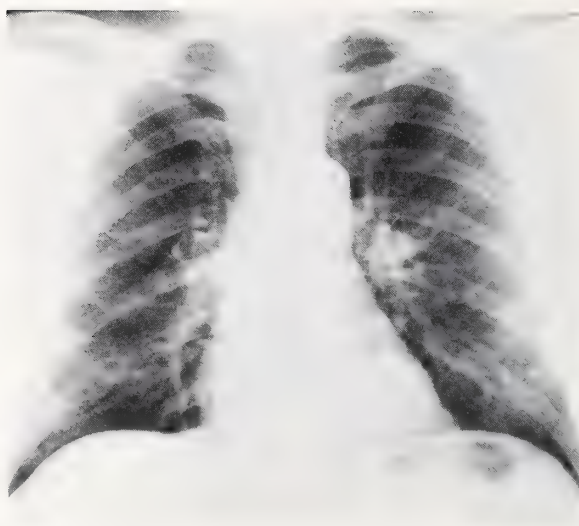
Bronchial adenomas have been recognized as clinical and pathologic entities for many years. The concept of this group of lesions began with Muller<sup>1</sup> and was later refined by Kramer,<sup>2</sup> Hamperl<sup>3</sup> and Enterline and Schoenberg.<sup>4</sup> However, not until Smetana's description in 1952<sup>5</sup> did the mucoepidermoid bronchial tumor join the carcinoid and the adenoid cystic lesions of the bronchus as a member of this controversial group.

Turnbull recently documented that all three of these neoplasms were potentially malignant and that mucoepidermoid tumors have the worst

prognosis.<sup>6</sup> Approximately 50 cases of mucoepidermoid bronchial tumors have been reported in the English-language literature. Turnbull's series is the largest with 12 cases which all behaved in a malignant fashion.<sup>7</sup> Prior to his report, Oslu<sup>8</sup> and Dowling<sup>9</sup> described metastasizing mucoepidermoid tumors of the bronchus. More recently, Axelson, Burcharth and Johannsen<sup>10</sup> presented four more malignant examples of this tumor. Yet a number of authors have emphasized the benign course that these neoplasms may follow.<sup>11-14</sup>

We are reporting three additional cases of mucoepidermoid bronchial neoplasms. One devel-





Figures 1a, 1b

Chest X-rays from Case 2: a) Normal chest X-ray taken two years prior to admission; b) X-ray at time of admission showing left hilar mass.

oped widespread metastases and was rapidly fatal. The other two patients were apparently cured by surgery.

#### Case 1

A 70-year-old white female had been well until seven months prior to her final admission when she complained of a productive cough. She was a non-smoker. Chest X-ray showed a mass in the right middle lobe. She subsequently underwent a right middle-lobe lobectomy. Her condition progressively deteriorated over the next few months; finally, she was admitted to this hospital in a coma and died shortly after admission. At autopsy, metastases were present in both lungs, the dura mater, the liver, both adrenals and in bone.

#### Case 2

A 54-year-old white male presented with hemoptysis and a productive cough. He had smoked heavily for 20 years but had quit 18 years previously. Chest X-ray revealed a left hilar mass which had not been presented on a previous chest X-ray taken two years earlier (Figure 1). Bronchoscopy was performed and a small polypoid tumor was visualized in the left upper lobe bronchus. A left upper lobectomy was then performed. The patient remains alive and well three years postoperatively.

#### Case 3

A 15-year-old white male was admitted to an-



Figure 2

Chest X-ray from Case 3. Calcified suprahilar lymph node can be seen without difficulty.

other hospital with complaints of productive coughing and intermittent hemoptysis for five months. Chest X-ray showed several small, calcified nodules in the hilum of the left lung (Figure

2). Tomograms revealed an endobronchial mass in the left main-stem bronchus (Figure 3a, b). Bronchoscopy disclosed a polypoid mass in the left main stem bronchus. A left bronchotomy was performed, and the lesion was resected with a margin of normal bronchus. The lung parenchyma was not involved as no lung tissue had to be removed. Four years after surgery, the patient is alive and healthy.

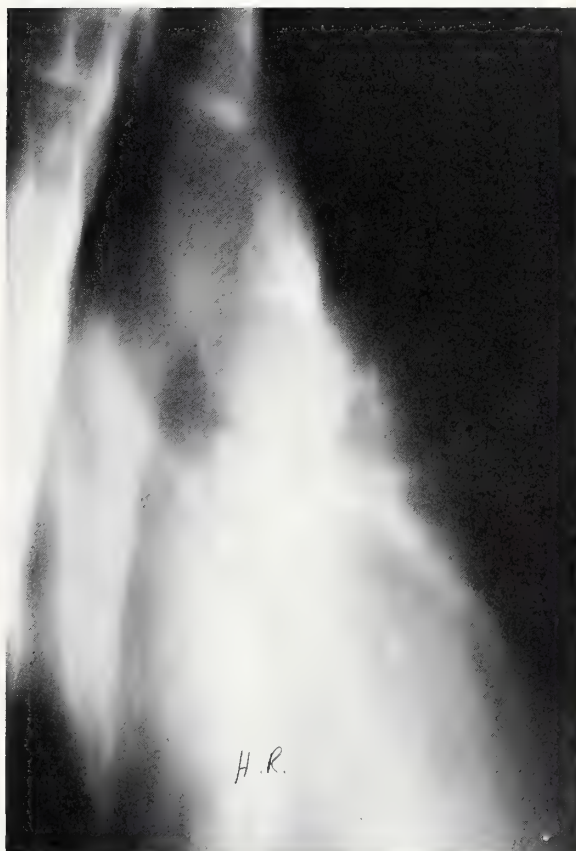
### Pathology

The lobectomy specimen from Case 1 contained a 3x 2x 3cm firm, gray tumor, arising from the wall of the major bronchus. Grossly, the border of this lesion appeared to infiltrate the adjacent lung parenchyma. Microscopically, this tumor was composed of well-differentiated mucus-producing glands, squamous cells and basal-like intermediate cells which were frequently found floating in mucinous lakes (Figure 4). At autopsy, poorly differentiated adenocarcinoma was metastatic to both lungs, the dura mater of the brain, the liver, both adrenals and bone. No epidermoid elements were found in the autopsy material.

Both specimens from the other cases contained small bronchial neoplasms. In Case 2, the tumor arose from the left main-stem bronchus, was polypoid and measured less than 1cm. in diameter. The cut surface was tan and gelatinous. Grossly, infiltration into surrounding tissue was not noted. In Case 3, the tumor was firm and tan and measured 2x1x1cm. On cut section, it appeared to arise from the portion of attached bronchus. Microscopically, both these lesions were consistent with well-differentiated mucoepidermoid tumors (Figures 5 and 6).

### Discussion

Cases 2 and 3 apparently represent examples of low-grade mucoepidermoid carcinomas that were cured by surgical resection. The aggressive behavior displayed by the tumor in Case 1 is interesting because of the lesion's initially well-



Figures 3a, 3b

Tomograms of left hilum from Case 3: a) A-P tomogram showing an endobronchial lesion; b) 55° oblique tomogram of the left hilum providing better visualization of the trachea and left main stem bronchus. The endobronchial tumor is seen to originate just proximal to the left upper lobe bronchus. The calcified hilar lymph node is also seen.



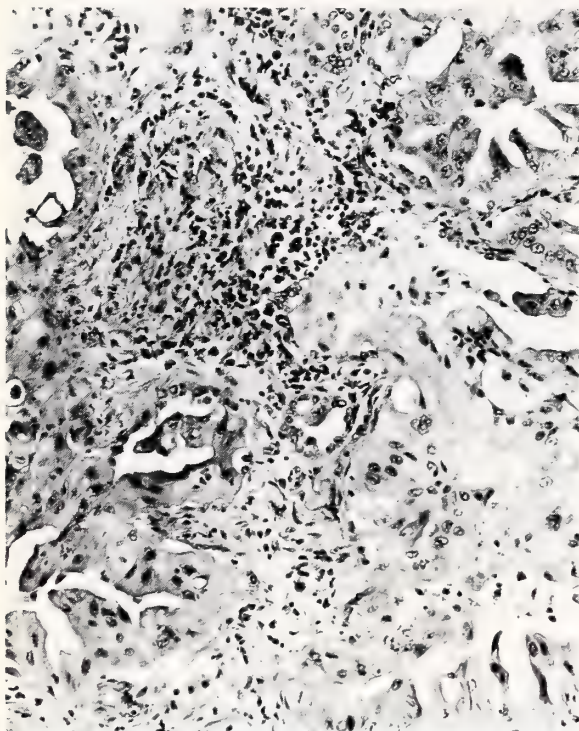


Figure 4

Mucin-producing columnar cells form well-differentiated glandular structures. Additionally, intermediate cells are present. Characteristic squamous cells were seen in other microscopic fields.

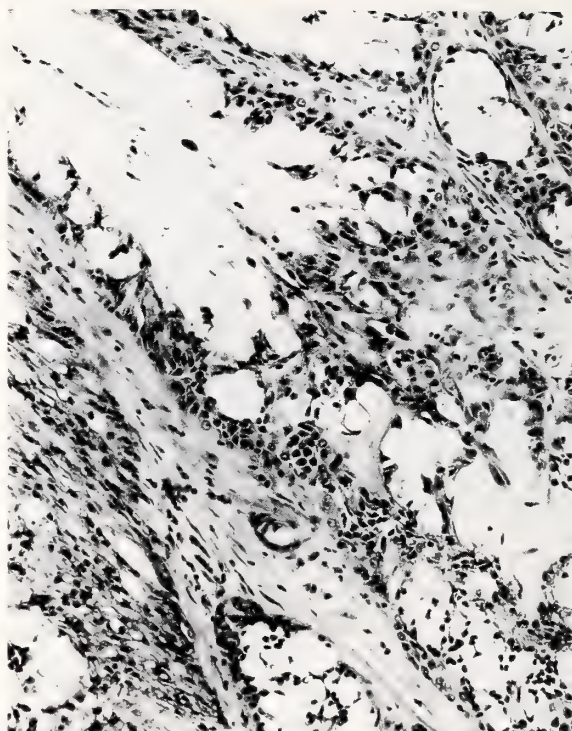


Figure 5

Sections show mucin containing cells and numerous intermediate cells.

differentiated histologic appearance. Mucoepidermoid tumors of the bronchus were once considered bronchial adenomas. For example, Meckstroth in 1961 described these neoplasms as slow-growing lesions that failed to metastasize.<sup>12</sup> However, more recent work by Turnbull has emphasized the tumor's malignant potential. He reviewed 5,500 patients with all types of lung cancer: only 12 mucoepidermoid tumors were found; of these, all 12 were dead from their disease within 15 months of admission.<sup>7</sup>

Turnbull proposes that the mucoepidermoid tumor of the bronchus is similar to that found in the salivary gland.

The mucoepidermoid bronchial carcinoma may be a low, middle or high-grade malignancy rather than an adenoma. Reported cases showing a relatively benign clinical course were assumed to be low-grade carcinomas.<sup>7</sup>

Mucoepidermoid bronchial tumors may resemble those found in major salivary glands because the mucus glands in these two locations are phylogenetically similar. Batsakis describes six types of cells found in mucoepidermoid carci-

nomas of the salivary glands, maternal, intermediate, columnar, mucous, epidermoid and clear. The maternal cells are felt to be the original tumor cells. They are the size of a lymphocyte, rounded, with scant basophilic cytoplasm. These cells give rise to columnar mucin-producing cells, mucinous cells (having mucin-filled cytoplasm and flattened, peripherally-located nuclei) and intermediate cells which resemble basal cells. The intermediate cells then may differentiate to form either clear cells, mucinous cells or epidermoid cells. In the salivary glands and bronchus, mucoepidermoid carcinomas are graded histologically. Low-grade tumors show well-formed glands with little nuclear pleomorphism. Middle-grade tumors have moderate pleomorphism, more epidermoid and intermediate type cells and solid, cellular nests. High-grade neoplasms are quite anaplastic but still must show at least three types of cells (mucin-producing, intermediate and epidermoid) to be classified as mucoepidermoid carcinomas. Only 10-15% of all mucoepidermoid salivary gland tumors metastasize, compared to 66% of the high-grade lesions.<sup>15</sup> Markedly pleo-



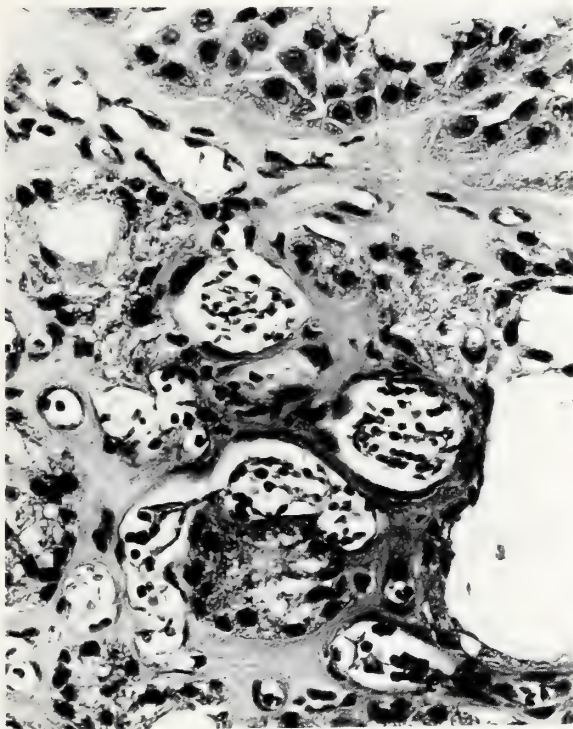


Figure 6

High power photomicrograph shows squamous element of tumor with distinct intercellular bridges. Adjacent to this region are mucin containing cells and small blood vessels.

morphic mucoepidermoid carcinomas of the bronchus also have a poor prognosis.<sup>7</sup> The neoplasm in our first case was unusual. Although the tumor appeared low-grade at lobectomy, it later metastasized widely as a poorly differentiated adenocarcinoma. Therefore, the behavior was similar to that of a high-grade malignancy, in spite of an originally rather benign, histologic appearance. The other two cases were small, low-grade tumors, resected at a curable stage. Thus, mucoepidermoid carcinomas of the bronchus remain a poorly understood entity. Originally felt to be a benign lesion, the tumor has been shown to have metastatic potential. This malignant behavior may, but does not always, correlate with the histologic grade of the carcinoma.

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**DENISE V. HIDVEGI, M.D.**, is a board certified anatomic pathologist and cytologist affiliated with the Northwestern University Medical Center, Chicago. Dr. Hidvegi is an assistant professor in both the departments of pathology and OBGYN at the Northwestern University Medical Center and also the director of cytology service, department of pathology, Northwestern Memorial Hospital.

**ROBERT M. VANECKO, M.D.**, is a board certified thoracic surgeon affiliated with Northwestern Memorial Hospital in Chicago. An associate professor in clinical surgery for the Northwestern University Medical Center, Dr. Vanecko is treasurer for the American College of Chest Physicians and a member of the Board of Governors for the Chicago Heart Association.



**BARRY D. LIFSHULTZ, M.D.**, is a resident in forensic pathology at the Cook County Medical Examiner's Office, Chicago. Dr. Lifshultz is a member of both the American College of Pathologists and the American Society of Clinical Pathologists.



# Malaria in a Community Hospital

By PAUL M. GEKAS, M.D./GENEVA

*Two cases of malaria seen in a community hospital are presented. The increased incidence of malaria, both worldwide and in the United States, is discussed. The importance of prompt recognition and therapy is emphasized.*

The incidence of malaria, both worldwide and in the United States, has been steadily increasing over the past 15 years. It is estimated by the Center for Disease Control that 50% of the world's population resides in malarious areas.<sup>1</sup> The World Health Organization estimates that 150 million cases of malaria occur yearly and that in Africa alone one million deaths occur annually.<sup>2</sup> In the United States there were 566 cases reported in the first six months of 1980 compared to 165 cases during the corresponding period in 1979. Following is a report of two cases seen in a community hospital recently, each demonstrating important aspects of this disease.

## Report of Cases

**Case 1.**—The patient was a 42 year old white male who was employed as a water resource consultant. He had recently returned from West Africa with a history of general malaise, headache and fever. He subsequently noted that his urine had become quite dark and he was experiencing left flank pain. He had no significant past history and was on no medications, including no recent malaria prophylaxis.

Physical exam revealed an alert white male in mild distress. Admission temperature was 101°F and later that day spiked to 104.6°F. He was non-icteric and there were no petechiae. Heart was normal except for sinus tachycardia, lungs were clear, abdomen was soft and non-tender and there was no hepatosplenomegaly. Initial laboratory work revealed hemoglobin of 16.3, hematocrit of 46, urinalysis showing 200RBC/hpf and normal

BUN and creatinine. Because malaria was highly suspected, thick film blood smear was analyzed and showed 200 ringed malarial forms/cc.

Chloroquine was started but patient continued to have fever with chills. The patient's urine output began to decrease and the creatinine rose to 1.8. Large amounts of IV fluids supplemented by mannitol were given to maintain an adequate urine output. The following day, a repeat thick smear showed 24,024 ringed forms per cc, but the temperature which had risen to as high as 105°F had fallen to 100°F. Over the next few days the temperature returned to normal, with gradual clearing of urine to a more normal color, and continued decrease of ringed forms seen on blood films. By day five the patient was afebrile and no parasites were seen. The serum bilirubin which had been elevated to 2.8mg% had returned to normal as did the serum creatinine. He was discharged on the seventh day.

**Case 2.**—The patient was a 46 year old white male admitted with a three day history of chills, fever and malaise. He had recently returned from a hunting safari in Africa. He had taken primaquine 26.3mg weekly just prior to his departure and weekly while he was in Africa. He was admitted because of severe headaches, nausea, high fever, and pronounced diaphoresis.

Physical exam revealed a temperature of 103.8°F, pulse rate of 130/min. and respirations at 24/minute. Heart, lungs and abdomen were normal and there was no scleral icterus or skin rash. Initial lab work revealed normal urinalysis, hemoglobin of 15.1, hematocrit of 43 and WBC=4200. Bilirubin was 1.0mg% but slight elevation of alkaline phosphatase, LDH and SGOT was present. Because malaria was suspected thick smear blood film was done which initially showed 3400 parasites/cc. The following day this had risen to 15,604/cc. The appearance was characteristic of falciparum malaria and the patient was treated with chloroquine 600mg initially, then 300mg in six hours followed by 300mg daily for two days. His response to chloroquine was excellent, manifested by a return to a

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PAUL M. GEKAS, M.D., is an internist and gastroenterologist affiliated with Community Hospital in Geneva and Delnor Hospital in St. Charles. He completed a two year gastroenterology fellowship at Baltimore City Hospital and Johns Hopkins Medical Center in 1978, and also spent a year practicing general medicine in rural Africa. Dr. Gekas cites a particular interest in parasitic disease.

normal temperature and improvement in his clinical condition.

#### Comment

The first patient probably manifested a condition known as the "pre-blackwater" state. It is characterized by toxemia, slight jaundice, dark urine and hepatomegaly. Therapy at this stage can prevent development of the more dangerous blackwater fever. Its characteristics include chills, jaundice, dark urine and rapidly developing anemia. It is due to acute intravascular hemolysis with hemoglobinuria, oliguria and renal insufficiency. Prompt therapy with chloroquine, appropriate hydration, mannitol and alkalization of the urine to minimize cast formation form the cornerstones of therapy. Peritoneal or hemodialysis are helpful if the above measures fail.<sup>3</sup>

The second patient demonstrated a common problem, that of inappropriate prophylaxis. Although he faithfully took his Primaquine both before and after his trip, his dosage schedule was incorrect. When used for prophylaxis, primaquine should be taken for 14 days after leaving the endemic area in a dosage of 15mg per day. The drugs of choice for malaria prophylaxis, however, are the 4 aminoquinolines with chloroquine being the most popular of these. It is administered in weekly doses beginning two weeks prior to departure and continuing for six weeks after departure from the endemic area. The entire subject of treatment and prophylaxis has been reviewed.<sup>4</sup> The recent emergence of resistant strains to chloroquine make it mandatory for the prescribing physician to be aware of the changing recommendations of malaria prophylaxis. Likewise, not only is it important to obtain a history of recent travel but to also inquire about future destinations.<sup>5</sup>

A major difficulty in the treatment of malaria in this country is delay in making the diagnosis. The average length of time for proper diagnosis in civilian hospitals is four days, while in military hospitals it is often made in the first 24 hours. In one major study there was a 24-fold increase in the case-fatality ratios of patients treated in civilian hospitals compared to military hospitals.<sup>6</sup> A second study done by a university hospital revealed that only 13% of patients referred for unexplained fever had the correct diagnosis of malaria prior to transfer. The major problems were in not eliciting a history of travel, ascribing symptoms of malaria to "flu or viral syndrome" or gastroenteritis or in starting inappropriate empiric therapy.<sup>7</sup> Major reasons for successful therapy in patients with malaria are rapid recognition of the situation, confirmatory laboratory studies and institution of therapy.

#### Summary

The number of reported cases of malaria is going up steadily each year. Many of these cases are from military personnel who had served in Southeast Asia and from aliens entering this country as unknowing carriers of the disease. A large number, however, are being diagnosed in American civilians returning from travels in Africa, Central America, Mexico and Asia. Rarer sources of malaria include transmission via transfusion therapy of whole blood,<sup>6</sup> packed erythrocytes, leukocytes, plasma and platelet concentrates.<sup>8</sup> In addition malaria is a diagnosis which must be considered in any febrile illness occurring in a drug addict because of transmission through contaminated shared injection apparatus.<sup>9</sup> A recent report from Canada of a patient with chronic lymphocytic leukemia who died from a febrile illness believed to have been malaria contracted twelve years earlier underscores the ubiquitous nature of the illness.<sup>10</sup>

The effects from this disease in the United States reflect a greater worldwide problem. An international attempt to eradicate malaria has been unsuccessful because of socioeconomic factors in underdeveloped nations, the emergence of DDT-resistant insects, drug-resistant strains of parasites and reduced support from agencies which initially funded the projects. Examples of this resurgence include India, which reported 50,000 cases in 1961 but which now has greater than three million, Thailand which reported 90,000 cases in 1972 but nearly one million by 1976, and Pakistan which reported 10,000 cases per year in the mid-1960's and nearly five million by 1975.<sup>2</sup> More developed countries in addition to the U.S. have felt the effect of this malaria resurgence.<sup>11</sup>

It is estimated that it costs nearly \$2,000 for diagnosis and treatment of a single case of malaria in a U.S. hospital as compared to \$1.67 for chloroquine prophylaxis.<sup>7</sup> In addition a recent paper reported three out of four cases of malaria were diagnosed on routine Wright-stain blood smears when characteristic organisms were seen. Significantly, malaria was not even considered as a diagnosis in one of these cases until the blood smear was examined.<sup>12</sup> Physicians, as well as other medical personnel must, therefore, retain a high index of suspicion so as not to miss an illness which can be expected to be seen with ever increasing frequency. ◀

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1. Promoting Health/Preventing Disease: Objectives for the Nation. U.S. Department of Health and Human Services, November 1980  
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# Case Reports

## *An Unusual Cause of Hemoptysis, Cough and Chest Pain*

### Swyer-James Syndrome

BY MILTON L. PAIGE, M.D. and JOEL R. BERNSTEIN, M.D./EVANSTON

*The clinical findings of hemoptysis, cough and chest pain in an elderly woman strongly suggested a diagnosis of pulmonary embolism, which was supported by localized hypoperfusion on the chest roentgenogram. However, a subsequent lung scan, pulmonary arteriogram and bronchogram revealed an unexpected diagnosis of Swyer-James Syndrome (unilateral hyperlucent lung).*

A 72-year-old female non-smoker presented with a one-week history of cough, several episodes of hemoptysis, and left-sided chest pain which increased with deep inspiration and was unrelated to position. Her history included multiple bouts of right-sided pleurisy. She also complained of orthopnea, dyspnea on exertion and one-block claudication. She was taking no medication. No previous history of thrombophlebitis, calf pain or leg swelling could be obtained. The only positive findings on physical examination were scattered rales and diminished breath sounds over the left lung.

Chest radiograph showed diminished vascular markings within the

left lung, especially the upper lung field (Figure 1). This finding in a patient with recent hemoptysis suggested a diagnosis of pulmonary embolism. A ventilation-perfusion scan followed by a pulmonary arteriogram were obtained. The ventilation scan (Figure 2a) using Xenon-133 showed a marked decrease in ventilation to the left lung. The perfusion scan using technetium-99m labeled albumin microspheres revealed an even greater decrease in the blood supply to the left lung (Figure 2b). The pulmonary arteriogram (Figure 3) showed the left pulmonary artery branches to be attenuated and decreased in number, and the main left pulmonary artery

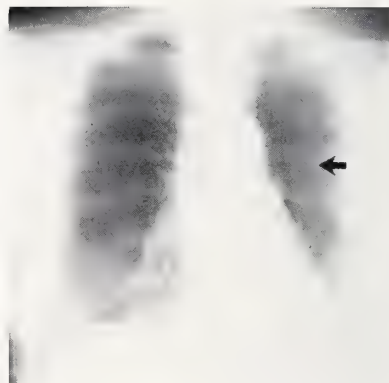


Figure 1

Frontal chest radiograph showing decreased pulmonary vascularity to the left lung (arrow).



**MILTON L. PAIGE, M.D.**, is a diplomate of the American Board of Diagnostic Radiology, affiliated with Evanston Hospital-Northwestern University Medical School, and Assistant Professor at the Northwestern University Medical School.



**JOEL R. BERNSTEIN, M.D.**, is a diplomate of the American Board of Diagnostic Radiology, affiliated with Evanston Hospital-Northwestern University Medical School, and Assistant Professor at the Northwestern University Medical School.

was hypoplastic. However, no vessels were obstructed or had intravascular filling defects to suggest pulmonary emboli. A subsequent bronchogram (Figure 4) revealed diffuse cylindrical bronchiectasis on the left without alveolar filling; findings consistent with obliterative bronchiolitis. This constellation of radiographic features is characteristic of Swyer-James Syndrome.<sup>1-6</sup>

#### Clinical Signs

Swyer-James Syndrome is radiologically manifested by significant



Figures 2a and b

Anterior views of the pulmonary ventilation (a) and perfusion (b) scans show markedly diminished aeration and blood flow to the left lung.

translucency of one or more lung lobes when compared to the opposite or normal lung parenchyma. This localized difference in aeration is usually the result of obstructive airway disease, *i.e.*, obliterative bronchiolitis with peripheral air-trapping and over-distention. Decreased vascular perfusion is also present, due to associated pulmonary artery hypoplasia.

The entity was first described in 1953 by Swyer and James<sup>1</sup> in a six-year-old boy. Subsequently, Macleod presented nine additional patients<sup>2</sup> and there are now more than 100 reported cases in the literature.

The majority of patients are asymptomatic children or young adults in whom a hyperlucent lung has been discovered on routine chest radiography. However, some patients complain of repeated or chronic respiratory infections and exertional dyspnea. Only six reported cases have presented with hemoptysis<sup>3</sup> which was the principal symptom of our patient. Various agents including adenovirus, mycoplasma, respiratory syncytial virus, measles and tuberculosis have been mentioned as possible etiologic factors.<sup>4</sup> All of these may cause acute bronchiolitis with small airway obliteration. As documented on bronchography (Figure 4) there is segmental and subsegmental dilatation of bronchi with conical termination of distal bronchi and failure of alveolar filling.<sup>5</sup> Such bronchial obliteration results in peripheral air-trapping, collateral air drift via the

pores of Kohn, and pulmonary over-distention. The concomitant decrease in perfusion to the affected lobe or entire lung adds to the radiolucency. The lung volume may appear normal or reduced. However, a contralateral mediastinal shift is usually evident on expiration films and indicates peripheral air-trapping.<sup>5</sup> Pulmonary angiography reveals hypoplastic hilar vessels and attenuated peripheral arteries (Figure 3).

The differential diagnosis of unilateral hyperlucent lung includes entities that alter chest wall thickness, including absence of the pectoralis muscles, scoliosis, and postmastectomy patients. Compensatory or unilateral obstructive emphysema may also result from central obstructing lesions, such as tumor, foreign body or congenital bronchial lesions that produce a ball-valve mechanism. Congenital vascular lesions such as absence or hypoplasia of the pulmonary artery and acquired pulmonary thromboembolism may cause hyperlucency due to a decreased blood pool without any recognizable bronchial abnormalities.<sup>6</sup>

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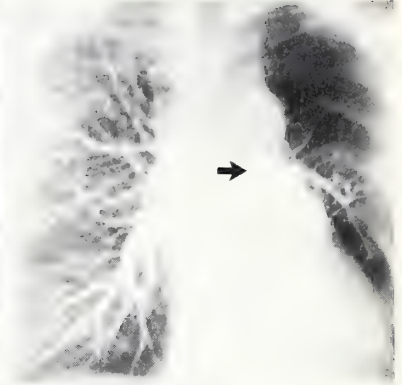


Figure 3

Pulmonary angiogram demonstrates left main pulmonary artery hypoplasia (arrow) and attenuated peripheral branches.



Figure 4

Selective left bronchogram demonstrates cylindrical bronchiectasis with absence of alveolar filling.

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# Case Reports

## Reversible Type III Hyperlipidemia Caused by Estrogen Administration

BY SAM J. SUGAR, M.D., F.A.C.P./EVANSTON

*Dysbetalipoproteinemia (Broad Beta Disease, Type III Lipidemia) is a rare disorder, usually transmitted as an autosomal recessive trait and characterized by accumulation of large amounts of Beta and pre-Beta lipoproteins. The older term, Xanthoma Tuberosum, described typical tuberoeruptive lesions common in this state. A secondary form of this disease can occur with hypothyroidism or Systemic Lupus. A case of symptomatic Type III hyperlipidemia due to exogenous estrogen administration is described.*

The patient was first seen for a preoperative consultation prior to hysterectomy for symptomatic uterine fibroids. There was a strong family history of coronary artery disease and a history of tachyarrhythmia requiring quinidine to control palpitations. She took no other medication. Thyroid function was normal. Cholesterol was 222, (nl 150-300) triglycerides were not measured. After hysterectomy the patient's gynecologist prescribed conjugated estrogen, 0.625mg. daily. She developed post-operative lactative symptoms, which resolved with discontinuation of estrogen. Because of postsurgical acute menopausal symptoms, the premarin was restarted.

Eighteen months after the first visit, patient had complaints of fatigue and worsening palpitations. Doses of conjugated estrogen were increased to 1.25mg. per day. She saw a neurologist for weakness and arm pain, decreased energy and endurance, blurred vision and dizziness. No concrete diagnosis was given. Patient returned nearly four years after initial visit, complaining of facial edema, palpitations, RUQ pain, easy bruising and loose bowels. No Xanthomata were seen on exam. UGI was normal. Cholecystogram showed milk of calcium bile only. Biochemistries showed marked abnormality in lipid levels. Serial cholesterols performed after adequate fasting were 745, 725mg%. Concurrent triglycerides were 2810, 1945mg%. Lipoprotein electrophoresis shows a broad beta band total of 1180mg%. Estrogen was discontinued. No dietary changes were made. One month later, symptoms of fatigue, dizziness and palpitations and abdominal pain had abated. Facial edema disappeared. Repeat lipoelectrophoresis showed cholesterol 290mg%, triglycerides 200mg% (nl up to 210) and beta lipoproteins only slightly elevated to 435mg%. Pre-Beta was 189mg% (normal).

### Discussion

Type III Dysbetalipoproteinemia is an uncommon disease which usu-

ally is detected by physical findings of Xanthomata. Premature peripheral and coronary arterial disease complicate its course.<sup>1</sup> This patient demonstrated protean symptoms (which cleared when her lipid levels fell) despite the absence of any Xanthomata. This disorder can be secondary to hypothyroidism or systemic lupus erythematosus. This patient demonstrates that estrogens can also cause dysbetalipoproteinemia, producing confusing symptoms without Xanthomata. Clinicians should be alert to vague systemic symptoms in patients receiving estrogens and consider evaluation of lipid profiles. Cessation of estrogens can result in resolution of symptoms. This may be of great importance, since in some cases of Type III Hyperlipidemia, atherosclerotic lesions can be seen to regress with improvement in the lipid levels.<sup>2</sup> ◀

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**Sam J. Sugar, M.D., F.A.C.P.**, is a board certified internist affiliated with Evanston Hospital and Glenbrook Hospital. He is an associate professor in medicine for the Northwestern University School of Medicine and has served as director of health services for the Hebrew Theological College. A member of the ISMS House of Delegates, Dr. Sugar has also served on the ISMS Medical-Legal Council.

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## Viewbox

(Continued from page 315)

### Answer: B—Digital Subtraction Angiogram



Figure 2

Figure 2 represents an image from the Digital Subtraction Angiogram (DSA) study demonstrating stenosis of the carotid artery. Patient motion, however, partially obliterates detail of the right internal carotid artery. Figure 3 is a conventional angiogram of the same patient for comparison. Other areas where DSA may be useful are illustrated by the following selected studies.

In the last ten years, a number of new imaging modalities have emerged to supplement and, in some cases, replace conventional radiographic techniques for the examination of specific regional anatomy or organ systems. This list includes computed tomography (CT), ultrasound, and dynamic isotope scanning. More recently Digital Subtraction Angiography (DSA) has emerged as a useful tool for the evaluation of certain vascular diseases. Unfortunately a wide array of names have been attached to this recording modality, which may lead to some confusion in under-



Figure 3

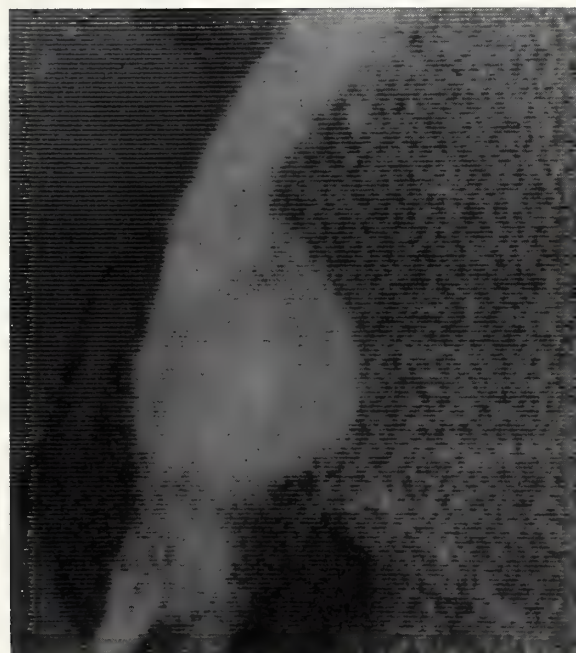
standing its capabilities. Other names which have been applied include Digital Fluoroscopy (DF), Computerized Fluoroscopy (CF), Digital Video Subtraction Angiography (DVSA), and Photoelectric Intravenous Angiography (PIA).

Digital Subtraction Angiography is an electronic recording medium for video images that have been derived from a conventional X-ray fluoroscopic unit. As part of the recording process, the electrical signals representing these video images are passed through special electronic circuits which prepare them for processing by a digital computer. This processing leads ultimately to an enhanced display of blood vessels containing contrast material in concentrations much lower than necessary for successful conventional angiography. Additional modifications of these electrical signals then permit each series of images to be displayed in a format in which all structures except blood vessels have been subtracted. Subtraction eliminates super-imposed shadows caused by bones and other tissues and leads to further enhanced visualization of intravenously injected contrast agents. Because the images are recorded in an electronic medium instead of on film they are available immediately for viewing on a standard T.V. monitor. When necessary, copies of these images may be recorded on conventional film systems for later viewing.<sup>1</sup>

When compared to conventional film angiography, DSA has inferior spatial resolution. In the



**Figure 4**  
DSA demonstrating an abdominal aortic aneurysm.



**Figure 5**  
DSA demonstrating a femoral artery aneurysm.

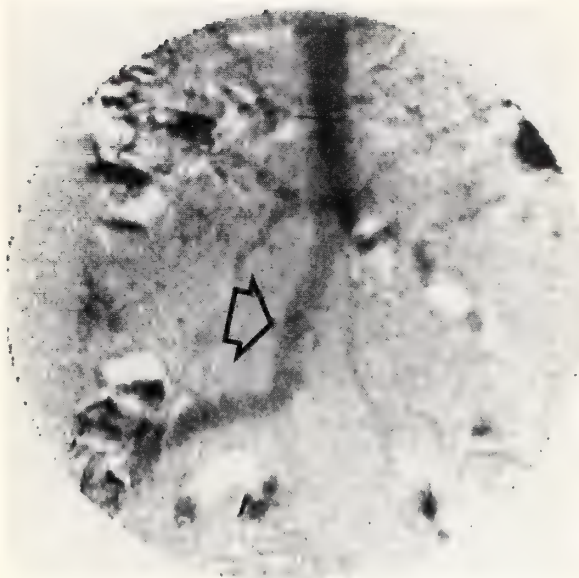
current application of this technique, however, DSA's vastly superior contrast resolution more than makes up for its inability to detect minute detail. High contrast resolution is the feature of this modality which permits the reliable dem-



**Figure 6**  
DSA of aortofemoral graft demonstrating the distal anastomosis (arrow head). Stenosis or leak was not present on multiple views.

onstration of intravenously injected contrast material after it passes through the cardiopulmonary circuit (undergoing dilution) and enters the arterial tree. Capitalizing on the high contrast resolution of this modality, studies of the arterial system may be carried out by injecting contrast material into a peripheral arm vein or, more commonly, through a catheter inserted into the superior or inferior vena cava from a puncture site in the groin or antecubital fossa. In this way some of the morbidity associated with conventional arterial catheterization procedures (*i.e.* embolization) can be avoided. Most patients can be studied as outpatients.<sup>2</sup> This procedure at its current level of development does not replace conventional arteriography but can be used to screen many patients for vascular disease who might not otherwise be considered candidates for conventional angiography. The technique is considered to be an effective screening examination for carotid artery disease and also appears useful in screening patients for renal vascular disease. It provides a simple means of following patients who have had peripheral vascular surgery and/





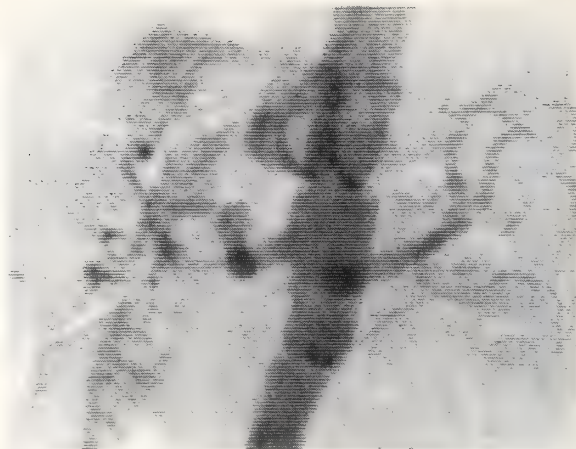
**Figure 7**

DSA of right iliac artery, post iliac artery dilatation. (arrow head) There is no evidence of stenosis.

or angioplasty and may prove useful in studying certain diseases of the central nervous system. At present, the technique is not suitable as a screening examination for evaluating peripheral vascular disease in the lower extremities, or for evaluating coronary arteries pre- or postoperatively.<sup>1-3</sup>

In order to ensure a successful examination, complete patient cooperation is necessary. The patient must be able to remain motionless and suspend respiration during the 10-20 second period during which image data is being collected. During studies which encompass the neck, the patient must not swallow. Unfortunately any motion due to respiration, swallowing or body movement introduces artifacts in the final image which can completely obscure details of the vascular structures being studied.

In summary, DSA is an electronic medium for recording conventional fluoroscopic images. Due to the exquisite contrast sensitivity of this recording technique contrast media in very low concentrations can be detected, and a clinically useful image produced. At the present time, DSA is most widely used in the evaluation of patients with suspected carotid occlusive disease. The question as to whether DSA will replace conventional angiography in the preoperative evaluation of carotid occlusive disease is not yet settled, although DSA is the sole angiographic examination used for this purpose in many patients at several institutions. Whether or not the use of this modality truly produces significant cost savings is not known.<sup>4</sup>



**Figure 8**

DSA of abdominal aorta at level of renal arteries post endarterectomy of renal arteries for correction of severe renal artery stenosis. The arteries are widely patent.



**Figure 9**

DSA done after intra-arterial injection of 5cc contrast material demonstrating recurrent CNS tumor (arrow head).

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Significant medical advances, innovative methods of treatment, the development of new medications—these have played important roles in improving the quality of life for the older generation. In addition, there are now many social services available to help the elderly cope with their problems and enrich their lives.





***As with any age group, some cannot cope***

But advancing years do bring increased problems and, frequently, increased anxieties as well. Although many elderly people can cope with these anxieties—and can adapt to the inevitable changes of the later years—there are many who cannot. Their anxiety and psychic tension reach levels that can reduce their coping capacities, perhaps bringing productivity to a halt. Fortunately, the supportive care and empathy of the family physician go far to enhance the emotional well-being of these patients—and to ensure that life after 65 continues as active as before.

For some excessively anxious patients, pharmacological support may be indicated. Because of its special advantages and low-dose effectiveness, Valium (diazepam/Roche) 2 mg is an excellent choice for the elderly patient. Side effects more severe than drowsiness, fatigue and ataxia are rare and seldom serious. As with all CNS-acting agents, patients should be cautioned about drinking alcoholic beverages while on Valium therapy and engaging in potentially hazardous activities such as driving or operating machinery.

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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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# Doctor's News

**LEUKEMIA SOCIETY GRANT OPPORTUNITIES:** The Leukemia Society of America is accepting applications for 1983 grants to support research in the fields of leukemia and related disorders. The Society offers three awards to individuals whose work concentrates on uncovering cures for leukemia, the lymphomas, Hodgkin's disease, and multiple myeloma.

The Scholar Program awards five-year grants for a total of \$125,000 to researchers who have demonstrated distinct ability in the investigation of the specified fields. The Special Fellow Program awards two-year grants for a total of \$37,000 to intermediate investigators in postdoctoral research. The Fellow Program awarded two-year grants for a total of \$30,000 to promising young researchers.

All candidates must hold a doctoral degree but may not have attained the tenured status of associate professor. Deadline for filing applications is September 1, 1982. Only one application in each grant category from an individual sponsor will be considered. Reviews by the Society's Medical and Scientific Advisory Committee will take place next January, with funding to start July 1, 1983. Under special circumstances the Society may award a reduced grant for a shorter period of time.

For further information and application forms, write to Research Grant Program, Leukemia Society of America, 800 Second Ave., New York, N.Y. 10017.

**TWO ANNUAL PRIZE OFFERS**—The Institute of Medicine of Chicago is accepting papers for consideration in two annual research competitions. The Dr. and Mrs. Elven J. Berkheiser Prize for research in orthopaedic surgery offers an annual prize of \$750 for the best thesis for original research work in the field of orthopaedic surgery completed in 1982. The investigation may be in the fundamental sciences, provided the work has a definite bearing on orthopaedic conditions.

The John L. and Beatrice S. Keeshin Prize awards \$1,000 for the best thesis for original research work in the field of Gaucher's Disease or arthritis completed in 1982.

In each case, the greater part of the work must have been completed in a Metropolitan Chicago institution. Papers may not have been published prior to submission. Competition for 1982 is open to physicians who received their M.D. degree six years or less prior to July 1, 1982 excluding terms of active duty in the Armed Forces.

Manuscripts are to be submitted in quadruplicate with a resume (S.S.# requested) to the Secretary of the Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago, Illinois 60604 no later than November 22, 1982.

**CMS PROGRAM FOR PHYSICIANS**—"Effective Communications for the Foreign-Born Physician," a 10 week program, will be held from 4:30-6:30 p.m. each Wednesday, May 26 through July 28, at the Chicago Medical Society. Approved for 15 hours category 2 CME credit, the program is designed to help foreign-born physicians speak the English language with accepted pronunciation which may improve patient compliance and communication with colleagues.

Registration fee is \$250 for CMS members and \$300 for non-members. For more information contact The Chicago Medical Society, 515 N. Dearborn Street, Chicago, Illinois 60610.



**PHYSICIANS IN THE NEWS**—Recently re-elected medical staff officers at Grant Hospital of Chicago include **Hans Schlect, M.D.**, Chicago, president; **Jesus G. Vegal, M.D.**, Chicago, vice-president; **Raymond W. Petkus, M.D.**, Chicago, secretary; and **Ludwig Kaminski, M.D.**, Chicago, treasurer.

**Walter Fried, M.D.**, Chicago has been appointed associate dean, medical sciences and services, Rush Medical College, and assistant vice-president for medical affairs at Rush Presbyterian-St. Luke's Medical Center. Dr. Fried, an internationally recognized hematologist, had most recently served as professor of medicine, University of Chicago Pritzker School of Medicine and acting chairman, Department of Medicine, Michael Reese Hospital and Medical Center.

**Samuel M. Schall, M.D.**, Chicago was recently elected to the board of directors of the Illinois Society for the Prevention of Blindness. Dr. Schall is a member of the section of ophthalmology, Department of Surgery, Saint Joseph Hospital and a past president of the Chicago Ophthalmological Society.

Governor Thompson has appointed **Marshall A. Falk, M.D.**, Chicago, to the State of Illinois Hospital Licensing Board for a three year term. Dr. Falk, executive vice-president, University of Health Sciences/Chicago Medical School, is also president of the Illinois Council of Medical School Deans.

**Howard C. Burkhead, M.D.**, Evanston, has been elected vice president of the American Association of Senior Physicians. Dr. Burkhead, a member of the ISMS delegation to the AMA, is chairman of the association's executive committee.

**John R. Tobin, M.D., M.S.**, Oak Brook, has been appointed dean of the Loyola University Stritch School of Medicine. Dr. Tobin, contributing editor for the *IMJ* "EKG of the Month" column, has been chairman of the largest academic department in the school of medicine since 1969. Dr. Tobin was the 1980 recipient of Loyola's prestigious Stritch Medal and holds the John W. Clarke Chair of Medicine.

**Allen L. Horwitz, M.D.**, Chicago, has been selected as a Senior Research Fellow in Mental Retardation by the trustees of the Joseph P. Kennedy, Jr., Foundation. Dr. Horwitz has been awarded a two-year, \$50,000-per-year grant to continue his research in biochemical genetics and the biochemistry of connective tissue disorders. As part of a research team at The Joseph P. Kennedy, Jr., Mental Retardation Research Center at the University of Chicago, Dr. Horwitz's research includes the mucopolysaccharidoses and other lysosomal storage diseases.

**PMA DRUG SEARCH**—The Pharmaceutical Manufacturers Association Commission on Drugs for Rare Diseases is seeking information on "orphan" drugs and devices. These drugs have the potential for treating rare diseases but are not generally available to practicing physicians or patients.

The Commission has mailed brochures to research institutions, voluntary health organizations, drug firms and government agencies inviting information or research leads on promising compounds. The Commission will rely upon advice from outside consultants in evaluating suggested investigational drugs and devices. Those found to have promise will be brought to the attention of potential sponsors, such as pharmaceutical firms.

Further information may be obtained from the PMA Commission on Drugs for Rare Disease, 1155 15th Street, NW, Washington, D.C. 20005.

**AMA'S CONSUMER BOOK PROGRAM**—Three new volumes in AMA's book program are now available to the public. They are: *The American Medical Association Book of HeartCare*, *The American Medical Association Book of WomanCare*, and *The American Medical Association Book of BackCare*. These volumes stress prevention and provide authoritative health and medical care information to the reader. The books can be purchased at bookstores throughout the country for \$12.95 each. Direct bulk discount orders to Dept. FT. 4-6, Random House Inc., 201 E. 50th St., New York, N.Y. 10022.

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	Mazindol	Nonphenylethyl-amine	33-55 hrs.	1 & 2 mg tablet	Mild euphoria, mild stimulation
	Fenfluramine	Secondary	10-30 hrs.	20 mg tablet	Moderate sedation (mild to moderate depression, a side effect, is also sometimes designated as a CNS effect)
High Abuse Potential	Phentermine	Primary	19-24 hrs.	8 & 37.5 mg tablet, 8, 15 & 30 mg capsule, 15 & 30 mg capsule (resin complex), 15 & 30 mg timed release capsule	Mild euphoria, moderate stimulation
	Phenmetrazine	Secondary	7-9 hrs.	25 mg tablet, 50 & 75 mg prolonged action tablet	Marked euphoria, marked stimulation
	Amphetamine	Primary	10-30 hrs.	Various	Marked euphoria, marked stimulation

<sup>a</sup>Delayed release characteristics of certain dosage forms must also be taken into account.

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**CONTRAINDICATIONS:** Advanced arteriosclerosis; hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

**WARNINGS:** If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

**PRECAUTIONS:** Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

**ADVERSE REACTIONS:** *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

**DOSAGE AND ADMINISTRATION:** Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in the morning. Tenuate is not recommended for use in children under 12 years of age.

**OVERDOSAGE:** Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

**Reference:** 1. Abramson R, Garg M, Cioffari A, and Rotman PA: An Evaluation of Behavioral Techniques Reinforced with an Anorectic Drug in a Double-Blind Weight Loss Study. *J Clin Psych* 41:234-237, 1980.

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# Rheumatology Rounds

L. F. Layfer and J. V. Jones, Contributing Co-Editors

## Toe Pain in a Hypertensive Male

A 61-year-old male presented with acute onset right metatarsal-phalangeal joint (MTP) pain for 18 hours. Earlier that day he had awakened with tenderness and swelling near the joint. It rapidly became too painful to cover with either shoe or sock, and weight-bearing was excruciating. He denied similar episodes in the past, but had noted occasional twinges of pain about both MTPs. He also noted chronic early morning pain and stiffness in the distal joints of his fingers and thumbs. Past history revealed mild hypertension, treated with thiazide-diuretics for the past seven years, bilateral inguinal hernia repairs, and a TURP for prostatic hypertrophy. He denied renal calculi.

On examination, temperature was 100° oral, and blood pressure was 150/90. Positive findings were confined to the musculoskeletal system where Heberden's and Bouchard's nodes were prominent about the DIP and PIP joints respectively. The right MTP joint was warm, swollen and tender to touch, especially about the medial edge where erythema was noted. No bunion was present.

### Laboratory

CBC, urinalysis, EKG and chest X-ray were normal. SMA-18 was remarkable for a uric acid of 10.1. X-ray of the right foot revealed soft tissue

swelling about the MTP. Hand X-rays showed osteophyte formation and joint space narrowing about several DIPs and PIPs, as well as both first carpo-metacarpal joints. Aspiration of the MTP yielded 0.25cc of cloudy yellow fluid; microscopic exam showed WBCs only; Gram stain revealed no bacteria; polarized light exam with a red compensator showed strongly negative birefringent needle-shaped crystals in intra- and extra-cellular locations; culture of the fluid was sterile.

### Comment

Therapy of acute gouty arthritis must be distinguished from manipulation of hyperuricemia and prevention of further gouty attacks. Acute gout is an inflammatory condition resulting from an acute crystal-induced synovitis, and as such will respond only to medications with anti-inflammatory properties, not drugs which lower uric acid. Short courses of high dose non-steroidal anti-inflammatory agents like indomethacin® or phenylbutazone are the present drugs of choice. The time-tested use of high dose colchicine, either I.V., or oral, is still effective, although often not used for fear of poor tolerance (G.I. side effects with oral administration) or toxic manifestations (subcutaneous tissue necrosis with I.V. administration).

In the N.P.O. patient, such as a post-operative abdominal surgical case, however, I.V. colchicine may be the preferred choice, as may intra-articular steroids. Eventually, all crystal-induced arthritis abates spontaneously without residual joint destruction. Medications which manipulate uric acid levels have no effect in ameliorating the acute attack, and in fact may paradoxically precipitate a new attack or prolong an old one. It is only in the absence of joint inflammation that such drugs should be started.

Prevention of recurrent attacks and therapy of chronic tophaceous gout can be accomplished by lowering serum uric acid. The level should be decreased to below that of its solubility in blood (6.4mg%) as this allows tissue deposits of urate to redissolve in blood and be excreted in the urine. Two classes of drugs are available to accomplish this: xanthine oxidase inhibitors (allopurinol) decrease the production of uric acid through enzymatic blockade and thus lower both serum and urine uric acid; uricosurics (probenicid and sulfinpyrazone) lower serum uric acid by increasing urine uric acid concentration and thus overall urate excretion. The choice of drug class depends on the renal excretion of uric acid by the patient: those with low urine uric acids (underexcretors) have hyperuricemia due to decreased renal excretion, endogenous or drug induced, and thus may respond nicely to uricosurics; those with hyperuricemia and high urine uric acids (overproducers) are better treated with xanthine oxidase inhibitors, as increases in urinary uric acid concentrations by uricosurics may lead to renal calculi. Distinction between these two presentations is made by a 24-hour urine uric acid collection; 1,000mg per day uric acid excretion is in the high risk category for renal stones. As noted above, manipulation of uric acid by any of these drugs may precipitate an acute attack of gout in the first few months of therapy. This can be prevented by initiation of low dose colchicine twice a day for the first half year of treatment.

When to begin drug therapy for hyperuricemia centers around two questions: (1) is therapy needed to prevent gouty attacks or lessen tophaceous deposits? (2) is therapy needed to prevent renal calculi? Although serum levels of uric acid are roughly correlated with development of acute gouty arthritis, it may be years before enough tissue deposits develop to allow the first attack to occur. In addition, chronic tophaceous gout with its destructive potential does not occur before the appearance of multiple acute attacks, and harmful effects to vital organs by hyperuricemia cannot be demonstrated before the tophaceous stage occurs. Therefore, it seems prudent not to

treat the asymptomatic hyperuricemic patient prior to the first attack of gout: not all will have such attacks and tissue damage will not occur before them. The need to prevent renal calculi, however, may supercede that reasoning and demand therapy in a patient who is a hyperexcretor (over 1,000mg per day uric acid excretion on a normal diet). In such a case, therapy of hyperuricemia with allopurinol may be warranted prior to the first gouty attack to prevent recurrent episodes of kidney stones.

## Conclusion

The finding of crystals of uric acid in fluid from the swollen MTP supported a diagnosis of acute gouty arthritis as the cause of toe pain. Treatment was begun with indomethacin 50mg q.i.d., with lessening of symptoms within 24 hours and complete resolution within five days. A 24 hour urine uric acid was 450mg per day, suggesting underexcretion, possibly due to thiazide-diuretics, as the cause of his hyperuricemia. Treating physicians chose to discontinue his diuretic and substitute another antihypertensive agent in its place, and to observe him for further gouty attacks. At the end of two months, serum uric acid was 8.1 and his 24 hour urine uric acid was 600mg per day. A second attack occurred at the end of three months, and after resolution of this attack with two weeks of indomethacin therapy, probenicid and colchicine were started. Six months later, his serum uric acid was 5.8, he was without an interval gouty attack, and the colchicine was stopped. A 24 hour urine uric acid at that time was well below 1,000mg per day. Finally, his hand symptoms, which had been a source of chronic distress, were thought due to classic osteoarthritis unrelated to his hyperuricemia, and responded well to naprosyn, 250mg twice daily. ◀

## References

1. Steele, T.H.: "Diuretic Induced Hyperuricemia," quoted in Kelley W.N.: "Crystal-Induced Arthropathies," *Clin. Rheum. Dis.*, April 1977, 37-50.
2. Wallace S.L.: "The Treatment of the Acute Attack of Gout," quoted in Kelley, W.N.: "Crystal-Induced Arthropathies," *Clin. Rheum. Dis.*, April 1977, 133-144.
3. Fox, I.H.: "Hypouricemic Agents in the Treatment of Gout," quoted in Kelley W.M.: "Crystal-Induced Arthropathies," *Clin. Rheum. Dis.*, April 1977, 145-158.
4. Klinenberg, T.R.: "The Management of Asymptomatic Hyperuricemia," quoted in Kelley, W.N.: "Crystal-Induced Arthropathies," *Clin. Rheum. Dis.*, April 1977, 159-168.



# Illinois Society, American Association of Medical Assistants

## *Introducing the New President*

On April 24, 1982, Janet Binkowski, R.N., was installed as president of Illinois Society. Mrs. Binkowski is employed at Thomsen Clinic in Dolton, Illinois. Many of you will remember Phillip Thomsen, M.D., former Illinois State Medical Society president, for whom the clinic is named. Jean Berschinski, Thomsen Clinic Manager, was the installing officer at the Illinois Society, AAMA annual meeting hosted by the Rock Island Chapter.

Mrs. Binkowski talked recently with Mrs. Synobia H. Payne, charter member (local, state and national) who has been employed 33 years by the same OB-Gyn physician.

**JB:** How did you get involved in our organization?

**SP:** I attended a two day seminar, "The Medical Assistant's Efficiency Course" in October 1955. There it was decided that a professional medical assistants' organization should be formed. In 1956 the Chicago Medical Assistants Association was founded. Illinois Society and the American Association of Medical Assistants followed.

**JB:** As a long time member, what does the organization offer?

**SP:** Much can be achieved by our members—educational symposia, travel courses, workshops,

conventions and study courses to become certified medical assistants. Never have I attended an educational program that I did not return to my office with at least one new idea that would benefit me, and through me, my employer. In my travels city to city, state to state, I have acquired many new friendships, exchanged and discussed new and old ideas which have also been beneficial to me.

**JB:** It's remarkable that you have retained membership over so long a period of time.

**SB:** Having maintained an active, working membership I have enjoyed contributing whatever I could in helping our group to function as a professional organization over the years. It has been a two way relationship, taking what would be helpful to me and offering what I have learned to others.

I wholeheartedly recommend membership in Illinois Society, American Association of Medical Assistants and hope that every doctor will encourage his or her medical assistants to become active members today.

Information regarding Illinois Society, AAMA may be obtained from Janet Binkowski, RN, President, Illinois Society, 428 Adams, Dolton, IL 60419. ◀

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**Fiberoptic Colonoscopy**

August 25-27, 1982

**Fiberoptic Esophagogastric Endoscopy**

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## EKG

*(Continued from page 319)*

**Answers: 1. A 2.E**

This patient had paroxysmal supraventricular tachycardia at a rate of 190 beats per minute. The QRS is narrow and the P wave appears to be buried in the QRS. The sixth and seventh RR cycles in the top strip show the tachycardia starts with a cycle that is longer than the established tachycardia RR cycle. In addition, the tachycardia breaks to sinus rhythm by initially lengthening the RR cycle. This can be seen in the sixth RR cycle in the bottom strip.

These observations suggest that this is an atrioventricular nodal re-entrant tachycardia. This mechanism accounts for two out of three patients with paroxysmal supraventricular tachycardia when pre-excitation is not present. It often occurs in older patients who have organic heart disease.

Although our patient had chest symptoms suggestive of angina, his exercise test was negative. Since the tachycardia occurs due to a functional dissociation of pathways (dual pathways) in the atrioventricular node, maneuvers to make the node more refractory will help. Vagal maneuvers such as the Valsalva maneuver or carotid sinus massage are occasionally all that is needed. Drug therapy is directed at prevention of tachycardia initiation by suppression of atrial or ventricular extrasystoles as well as prevention of future attacks. Digoxin, Verapamil, and the beta blockade of propranolol all block the atrioventricular node and can help. There is a danger in using digoxin if the patient has pre-excitation. Our patient responded to digoxin alone. For further reading on this subject, see Delon Wu, *et al*, *American Journal of Cardiology* 41:1045, 1978. ◀



# Guide to Continuing Medical Education

## JUNE

### Cardiovascular Medicine

#### Thoracic Cardiovascular Medicine for the Clinical Practitioner

For: Cardiologists, GP's, FP's. Symposium, June 12-13, Westin Hotel, Chicago. **Sponsor:** Mt. Sinai Hospital Medical Center, California & 15th St., Chicago 60608. **Cosponsor:** U.S. Academy of Physicians & Surgeons. **Reg. deadline:** 5/31. **Fee:** \$125. **Reg. limit:** 400. **Credit:** Category 1, 12 hours. **Contact:** S. Jones. **Phone:** 312/542-2563.

### Diabetes

#### Diabetes Mellitus—1982

For: Primary care physicians. Symposium, June 4-5, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** TBA. **Reg. limit:** none. **Credit:** Category 1; AAFP Prescribed, AOA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

### Emergency Care

#### Cardio-Pulmonary Resuscitation Update

For: MD's. Lecture/demonstration, June 25, 11:00 a.m., Oak Park. **Sponsor:** CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Charles Weigel, MD. **Phone:** 312/366-7870.

### Endocrinology

#### Under- and Overactive Adrenal Function

For: MD's. Lecture, June 4, 8:00 a.m., Chicago. **Speaker:** Will Ryan, MD. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Sharon Smith. **Phone:** 312/883-2112.

### Family Medicine

#### Specialty Review in Family Practice

For: FP's. Lecture, June 1 (11 days), Chicago. **Speaker:** Harry Marchmont-Robinson, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$600. **Reg. limit:** 200. **Credit:** Category 1, 98 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Family Practice

#### Practical Office Oncology

For: FP's. Lecture, June 11 (1 1/2 days), Chicago. **Speaker:** John Merrill, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$175. **Reg. limit:** 90. **Credit:** Category 1, 12 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Family Medicine

#### 1982 Family Practice Update

For: MD's. Course, June 21-25, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, CME, 600 S. Paulina, Chicago 60612. **Fee:** \$300. **Reg. limit:** none. **Credit:** Category 1, 30 hours. **AAFP Prescribed,** 30 hours. **Contact:** Vickie O'Sullivan. **Phone:** 312/942-7119.

### Gynecology/Surgery

#### Open Laparoscopy Workshop

For: MD's. Workshop, June 5, 7:45 a.m., Chicago. **Sponsor:** Grant Hospital, 550 W. Webster Ave., Chicago 60614. **Reg. deadline:** 5/15. **Fee:** \$150. **Reg. limit:** 100. **Credit:** Category 1, 7 hours; ACOG, 7 cognates. **Contact:** Robert Mutterperl, DO. **Phone:** 312/883-2112.

### Internal Medicine

#### Prevention of Hepatitis B Virus Infection

For: MD's. Symposium, June 10, St. Louis, MO. **Sponsor:** CME, Washington University School of Medicine, Box 8063, 660 South Euclid, St. Louis, MO 63110. **Fee:** \$75. **Reg. limit:** 150. **Credit:** Category 1, 6 1/4 hours; AAFP Prescribed, 3 1/4 hours; AOA, 6 hours. **Contact:** Loretta Giacometto. **Phone:** 314/454-3873.

### Internal Medicine

#### Thrombolytic Therapy Symposium

For: MD's. Surgeons. Symposium, June 19, 8:30 a.m., Chicago. **Sponsor:** Edgewater Hospital, 5700 N. Ashland Ave., Chicago 60660. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 3 hours. **Contact:** June Gonzalez. **Phone:** 312/878-6000 x 414.

### Internal Medicine

#### Lake County Medical/Surgical Seminar

For: MD's. Seminar, June 15, 8:00 a.m., Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan 60085. **Contribution:** \$5. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312/578-2555.

### Internal Medicine

#### Problem Solving in Lung Disease: A Practical Approach

For: MD's. Course, June 2-4, Chicago. **Sponsor:** American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. **Cosponsors:** U of Chicago; Michael Reese Hospital and Medical Center. **Fee:** \$170-\$300. **Reg. limit:** 100. **Credit:** Category 1. **Contact:** Maxine Topping. **Phone:** 800/523-1546.

### Medicine

#### Infectious Disease—What's New?

For: MD's. Symposium, June 3, 3:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Reg. deadline:** none. **Fee:** \$40 pre. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### OB/GYN

#### Obstetrical Events and Neonatal Brain Injury

For: MD's. Conference, June 24-25, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** \$180. **Reg. limit:** none. **Credit:** Category 1, 12 hours; ACOG credit applied for; AOA, 12 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

### Pathology

#### Advances in Developmental Abnormalities: Clinical, Genetic

For: MD's, genetic counselors. Symposium, June 18-19, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** \$140. **Reg. limit:** none. **Credit:** Category 1, 11 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

### Pharmacology

#### New Therapeutics in Cardiology and Infectious Diseases

For: Primary care physicians, Cardiologists. Symposium, June 10-11, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, TBA; AAFP, TBA; AOA, TBA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

### Pulmonary Medicine

#### National Board Review in Pulmonary Medicine

For: MD's. Seminar, June 21-25, The Palmer House, Chicago. **Speaker:** Reuben Cherniack, MD. **Sponsor:** American College of Chest Physicians, 911 Busse Hwy., Park Ridge 60068. **Reg. deadline:** none. **Fee:** members, \$350; non-members, \$400. **Reg. limit:** none. **Credit:** Category 1, 32 hours. **Contact:** Dale Braddy. **Phone:** 312/698-2200.

### Surgery

#### Fluids and Electrolytes

For: Surgeons, Internists. Lecture, June 24 (2 1/2 days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$250. **Reg. limit:** 90. **Credit:** Category 1, 23 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## JULY

### Cardiology

#### Arrhythmias and Cardiac Ischemia

For: GP's, FP's, Internists. Seminar, July 30-Aug. 1, Boyne Mountain Resort, Michigan. **Sponsor:** International Medical Education Corp., 64 Inverness Drive East, Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **ACEP,** 13 hours. **Contact:** Doris Price. **Phone:** 800/525-8651 x 123.

### Cardiology

#### ECG Interpretation and Arrhythmia Management

For: GP's, FP's, Internists. Seminar, July 30-Aug. 1, the Abbey, Lake Geneva, WI. **Sponsor:** International Medical Education Corp., 64 Inverness Drive East, Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours; ACEP, 13 hours. **Contact:** Doris Price. **Phone:** 800/525-8651 x 123.

### Dermatology

#### Practical Office Dermatology: A Course for Clinicians

For: Internists, Pediatricians, GP's, FP's. Lecture, July 12-16, Chicago. **Speaker:** Marshall Blankenship, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Reg. limit:** 85. **Credit:** Category 1, 37 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Gynecology

#### Office Gynecology

For: Internists, GP's, FP's. Lecture, July 12-14, Chicago. **Speaker:** M. LeRoy Sprang, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$250. **Reg. limit:** 85. **Credit:** Category 1, 21 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Medicine

#### Environmental Medicine

For: Internists, GP's, FP's. Lecture, July 19-23, Chicago. **Speakers:** Stephen Greenberg, PhD; Emerson Day, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$325. **Reg. limit:** 85. **Credit:** Category 1, 30 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Medicine

#### Specialty Review in Pediatrics

For: Pediatricians. Lecture, July 19-24, Chicago. **Speaker:** Ira DuBrow, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 300. **Credit:** Category 1, 63 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Medicine

**Specialty Review Course in Internal Medicine/Certifying**  
For: Internists. Lecture, July 25 & Aug. 1, Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 600. **Credit:** Category 1, 72 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Urology

### Summer Clinical Series

For: Urologists. Course, July 30-31, Palmer House, Chicago. **Sponsor:** American Urological Assn., P.O. Box 25147, Houston, TX 77265. **Reg. deadline:** 7/30. **Fee:** yes. **Reg. limit:** 200. **Credit:** Category 1. **Contact:** Alice Henderson. **Phone:** 713/790-6070.

## AUGUST

## Electromyography

### Electromyography and Clinical Neurophysiology

For: MD's. Course, August 3-6, Chicago. **Speaker:** Ian MacLean, MD. **Sponsor:** Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago 60611. **Fee:** \$175-250. **Reg. limit:** 36. **Credit:** Category 1, 26 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

## Emergency Medicine

### Specialty Review in Emergency Medicine

For: Emergency Medicine Physicians. Lecture, August 2 (5½ days), Chicago. **Speaker:** James Matthews IV, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$425. **Reg. limit:** 175. **Credit:** Category 1, 45 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Family Medicine

### Family Practice Seminar-at-Sea

For: MD's. Symposium Cruise, August 7-14, Bermuda. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 30 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Internal Medicine

### Specialty Review in Hematology

For: Hematologists, Oncologists, Internists. Lecture, August 30 (5 days), Chicago. **Speaker:** William Donnelly, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 175. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Internal Medicine

### Specialty Review in Infectious Disease

For: Internists, Infectious Disease Specialists. Lecture, August 30 (5 days), Chicago. **Speaker:** Stuart Levin, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 175. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Internal Medicine

### Specialty Review in Pulmonary Disease

For: Pulmonary Specialists, Internists. Lecture, August 30 (5 days), Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 175. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Legal Medicine

### Medical-Legal Seminar-at-Sea

For: MD's. Symposium Cruise, August 14-21, Bermuda. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 30 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Medical Photography

### Diving Medicine Seminar-at-Sea

For: MD's. Symposium Cruise, August 7-14, Bermuda. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 30 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Medicine

### Specialty Review Course in Internal Medicine/Certifying

For: Internists, Medical Subspecialists. Lecture, August 1 (6½ days), Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 600. **Credit:** Category 1, 72 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Orthopedics

### Specialty Review in Orthopedics

For: Orthopedic Surgeons. Lecture, August 15 (7 days), Chicago. **Speakers:** Peter Altner, MD; James Callahan, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 175. **Credit:** Category 1, 68 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

### Fiberoptic Colonoscopy

For: Surgeons, Internists, Gastroenterologists. Lecture, August 25 (2½ days), Chicago. **Speaker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

### Fiberoptic & Esophagogastric Endoscopy

For: Surgeons, Internists, Gastroenterologists. Lecture, August 30 (2½ days), Chicago. **Speaker:** C. Thomas Bombeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

### Specialty Review in General Surgery, Part II

For: General & Specializing Surgeons. Lecture, August 16 (11 days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$600. **Reg. limit:** 300. **Credit:** Category 1, 99 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

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# REPORT

## FOR *Illinois Physicians*

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### **MENTAL ILLNESS AND ALCOHOLISM TREATMENT BENEFITS CHANGED FOR 1982 FEDERAL EMPLOYEE PROGRAM (FEP)**

Several changes were made in the benefits for inpatient care of mental illness and alcoholism treatment in the 1982 Blue Cross and Blue Shield Federal Employee Program (FEP) effective January 1, 1982.

The administration of these benefits has recently been modified by the Federal Office of Personnel Management as follows:

#### **MENTAL ILLNESS—HIGH AND LOW OPTIONS**

Subscribers in the hospital on January 1, 1982, who were admitted in 1981, are eligible to receive benefits at the 1981 level for this confinement period. In 1981, basic benefits were available for 365 days per confinement under High Option and 90 days per confinement under Low Option. Additional days may be eligible under the supplemental portion of the program.

Once a 60-day break occurs between discharge and readmission, the confinement is ended and the 1981 level of benefits ceases.

Subscribers who were admitted in 1981 and were readmitted in 1982, with less than a 60-day interval between discharge and readmission, are eligible for the continuation of that confinement period at the 1981 level of benefits, as described in the preceding paragraph.

#### **ALCOHOLISM REHABILITATION TREATMENT— HIGH AND LOW OPTIONS**

Alcoholism Rehabilitation Treatment Benefits were eliminated in the 1982 FEP Benefit Plan.

However, if an admission began in 1981 and the rehabilitation treatment program continued into 1982, 1981 benefits will continue until discharge or the 28 days are exhausted, whichever is first. A subsequent admission for a second 28 day treatment session is not covered.

An admission in 1981 for detoxification that is followed within 30 days by an alcoholism rehabilitation treatment program is eligible for 1981 benefit coverage. The days used for detoxification count toward the 28 days available. No benefits are available for a second treatment session.

The 1982 FEP Benefit Plan will continue to provide benefits for medically necessary detoxification.



# **FILING PHYSICIAN'S SERVICE REPORT FORMS FOR ILLINOIS BELL TELEPHONE EMPLOYEES**

Effective on January 1, 1982, Blue Cross and Blue Shield of Illinois began administering the Major Medical benefits for the Illinois Bell Telephone Company's active and retired employees. The group numbers for Illinois Bell under 65 and over 65, active and retired employees, are 51100, 51165, 35500, and 53604. The 1982 Illinois Bell contract is designed so that both Blue Shield and Major Medical benefits will be administered through single claim submission.

Claims for Illinois Bell members in groups 51100, 35500, and 53604 should be filed on a Physician's Service Report and sent to Blue Cross and Blue Shield of Illinois. All services will be processed and you will receive the amount of eligible Blue Shield benefits.

Any services eligible for Major Medical benefits will be shown as ineligible Blue Shield benefits on your Explanation of Payments Report. However, these services along with any remaining balance of Blue Shield benefits, will be automatically processed under the Major Medical portion of the Illinois Bell contract. The amount of eligible benefits for these services will then be sent to you. The Illinois Bell subscriber gets one Explanation of Benefits Report which outlines the amount of eligible benefits under both the Blue Shield and Major Medical coverages after all eligible benefits have been provided.

The Illinois Bell benefits program provides a wide range of physician services under its coverage. Examples of some physician services which are eligible under the Major Medical coverage are:

- office visits
- outpatient psychotherapeutic visits
- prescription drugs and supplies
- injections (excluding immunizations)

Any claims for Illinois Bell members who are eligible for Medicare in groups 51165 and 53604 should also be billed on a Physician's Service Report. Services billed for these members must include an Explanation of Medicare Benefits Report. For these Illinois Bell members, the Medicare payment on these services will be deducted, or "carved out," after eligible Blue Shield and Major Medical benefits have been determined. You will receive the total amount of eligible benefits, less the Medicare benefits, for both Blue Shield and Major Medical services. The member will again receive one Explanation of Benefits Report.

Remember, you must include the Explanation of Medicare Benefits Report with every claim submitted for Medicare eligible IBT patients.

# Medicaid-Medicare-Champus Report

## MMIS Update

ISMS recently completed a series of workshops which were designed to clarify confusing aspects of submitting IDPA claims under MMIS. During these seminars the ISMS staff received several questions regarding claim filing for specific procedures and services. This article will highlight those areas which have generated the most inquiries and provide answers for those problem areas.

ISMS suggests that physicians who bill the Department of Public Aid become familiar with the IDPA Medical Assistance Program Handbook for Physicians. This manual defines the programmatic and policy requirements for IDPA participation. The Handbook is available from the IDPA Provider Participation Unit, P.O. Box 4034, Springfield, IL 62768.

Below are some of the areas which generated questions at the ISMS Workshops.

**Cross-Over Claims:** ISMS highlighted the subject of cross-over claims in the December issue of the *Illinois Medical Journal*.

The current problem centers on the Explanation of Medical Benefits issued by EDS-Federal, the Medicare Part B carrier. When filing a cross-over claim the physician's office staff should indicate on Line 5 of the HCFA 1490 (Medicare claim form) that the patient is eligible for IDPA coverage and include the recipient's individual identification number. On line eight, the state license number of the physician rendering service should be entered on the Medicare claim form *in addition* to the Medicare-issued physician I.D. number. In order to bill Public Aid on *Medicare/Medicaid* eligible patients, the physician must accept assignment.

EDS-F will generate a special EOMB for IDPA processing purposes. In those instances where the physician is not aware that his patient is a Medicare/Medicaid recipient and necessary IDPA information is omitted from the HCFA 1490, EDS-F will issue its standard EOMB. A physician may submit the standard EOMB with a copy of the 1490 to IDPA for claim processing. However, *a statement indicating the reason* for not having the special EOMB must accompany the claim. These cross-over claims should be mailed in the *special handling*, pre-addressed envelopes.

**Injectable Drugs:** When billing IDPA for an injectable drug, the *drug* item number 60009981 is to be entered in the procedure code section of the claim form (Box 24-C). In order to bill for multiple injections, the *fourth* digit of the basic drug number (60009981) is to be changed to show the additional injections. As an example, the number 60019981 would be used to indicate two injections (etc.) The description and quantity of the drug should be identified in the blank space of Section 24-C on the claim form.

**Laboratory Tests:** Several questions have been raised at ISMS seminars on how to bill for laboratory tests. IDPA will reimburse a physician for lab tests done in the office by the physician or his staff using his equipment/supplies. Claims may only be submitted if the physician or his staff perform the lab tests. IDPA will not reimburse for samples drawn and referred to either a Public Health or an independent laboratory for analyses.

When submitting a claim for office laboratory work, the appropriate CPT-4 procedure code for the specific test is to be included in Section 24-C of the MMIS claim form. If the physician *only* performs laboratory tests during a patient visit, the physician may bill only for the lab work and not for the office visit.

Some physicians are also submitting claims for Vitamin B-12 injections. Vitamin B-12 therapy is a covered service only if: a) The presence of anemia is detected by a complete blood count; b) The anemia is determined to be of the macrocyte type, and c) An elevated serum lactic-dehydrogenase is determined. When submitting a claim for Vitamin B-12 injections the appropriate blood testing results should be appended to the claim.



**Radiology Procedures:** Some Radiologists are having claims rejected because the procedure is “illogical for the role.” This rejection usually occurs when billing for an invasive radiological procedure.

The injection of contrast media, and the placement of the needle or catheter is regarded as a surgical procedure and should be billed independently of the interpretation or the results. The appropriate CPT-4 procedure codes for most invasive services may be located in the #30000 series of the CPT-4 procedure code book. Radiologists should not bill IDPA using CPT-4 codes that are described as “complete procedure.” Additionally, when a physician submits a claim for multiple occurrences of an x-ray procedure on the same date of service, a single procedure code is to be entered in Section 24-C of the MMIS claim form. The number of occurrences should be entered in the “Day/Units” field (Section 24-F) of the MMIS claim form.

**Charging for Mileage:** When it is the physician’s usual practice to charge for mileage driven to a patient’s home or group care facility, the physician may submit mileage charges to IDPA. Mileage charges may be made from the city limits of the town in which he practices to the group care facility that he is visiting. Only one mileage charge may be made per visit regardless of the number of patients treated during a particular visit. The IDPA has developed a specific code to identify charges for mileage (99200) which should be entered in Section 24-C of the MMIS claim form. The total number of miles one way is to be entered into the “Day/Units” field of the MMIS claim form (Section 24-F). When a physician bills for mileage and subsequent procedures rendered to patients in a group care facility, the name and address of the facility must be included (in Section 21) on the MMIS claim form.

**Surgical Assistants:** IDPA will reimburse a physician for assisting at surgery only when the services of a resident or other salaried hospital staff physician are not available. Reimbursement will be made for only one surgical assistant. When a physician submits a claim for assistance at surgery, the Type of Service section must be completed with the number “8” to denote the role as an assistant. In addition, the Day/Units section should be completed indicating the duration of surgery. Time should be identified in minutes, for example, a one hour and a half surgery would be reported as 0090 in Box 24-F of the claim form.

**Obstetrical Care:** Some physician claims for obstetrical care, including the delivery, have been rejected for the procedure being illogical for the role. Physicians who submit claims for obstetrical care including a vaginal delivery should report the type of service in Box 23-E on the MMIS claim form as *medical care* Type of Service Code 1. However, IDPA does consider birth by cesarean sections to be a surgical procedure. Physicians who submit claims for cesarean section deliveries should report the type of service in Box 23-E of the claim form as surgery, Type of Service Code 2.

**Newborn Care/Circumcision:** Some offices have submitted bills for newborn care and circumcisions on the same MMIS claim form. This will result in a claim rejection for the procedure being illogical for this role. Newborn care is considered to be a medical Type of Service and should be reported as medical care in Box 23-E of the MMIS claim form. A circumcision should be considered as a surgical Type of Service. Claims for circumcisions should be submitted separate from claims for newborn care.

In addition, if the physician knows the individual recipient I.D. number of the child, he may enter the number in Box 8 of the MMIS claim form and forward the claim direct to IDPA for processing. Newborn care claims should be sent to the Eligibility Monitoring Unit *only* if the patient’s individual identification number is *not* known to the physician. For additional information on newborn care billing, please refer to the April issue of *Illinois Medical Journal*.

Additional information or clarification on IDPA policies and billing procedures may be obtained by calling your ISMS Field Representative at 312-782-1654. Physicians in Cook County may contact Christine Szuflika at the Chicago Medical Society at 312-670-2550.

Finally, physicians may direct inquiries to IDPA by calling the toll free numbers listed below:

(800) 252-8936—Provider participation questions (additional forms and envelopes).

(800) 252-8937—Policy and billing questions.

(800) 252-8942—Payment information.

# President's Page

## Medical Discipline



There are 22,000 physicians licensed to practice in Illinois. As in any professional group, or for that matter, any segment of the general population, there are undoubtedly some who are less than competent for one reason or another. Some are impaired as a result of alcoholism, drug abuse or mental deterioration. A few evidently have psychopathic tendencies.

Whatever the cause, no one, either in Illinois or in any other state, has ever been able to produce reliable figures which would indicate the magnitude of this serious problem. All of us know of a few colleagues whose professional medical behavior may be questionable. But, it is very unlikely that there are anywhere near as many bad doctors practising as recent newspaper articles and TV programs would like to make the public believe.

Nevertheless, this problem is of great concern to physicians generally, as evidenced by the fact that in questionnaires generated recently both by ISMS and CMS (the largest county medical society in the nation), the issue the respondents considered of greatest importance was disciplining physicians who commit unlawful or unprofessional acts.

In a recent two-year period, county medical societies in Illinois reviewed nearly a thousand complaints against physicians. Some of these reviews lead to reports to the Department of Registration and Education for further investigation. Medical societies have no legal standing and cannot subpoena physicians or their records. The only punishment they can impose is either suspension or revocation of membership in the medical society. Only the director of Registration and Education may suspend or revoke a physician's license.

In 1976, as a result of the initiative of the Illinois State Medical Society, the Medical Disciplinary Board was established to assist the director of Registration and Education in disciplinary decisions on physicians. This was accomplished despite Gov. Walker's veto of the legislation—a veto which was eventually overridden by an impressive margin. Since that time few of the provisions of the act establishing the Medical Disciplinary Board have been implemented, and those that have, only half-heartedly. On numerous occasions the Society has made formal complaints regarding these deficiencies to the successive directors of the Department of Registration and Education, and finally to the Governor himself, all to little avail.

What is required now, following public exposure to these deficiencies, is not necessarily more legislation but vigorous application of the law that is already in place. ◀

*C. C. Wiggishoff M.D.*

Cyril C. Wiggishoff, M.D., President



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**CARDIAC FAILURE** Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA.** Because of its beta-adrenergic blocking activity INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**USE IN PREGNANCY** The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

### PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

### ADVERSE REACTIONS

**Cardiovascular** bradycardia, congestive heart failure: intensification of AV block; hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

**Central Nervous System** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

**Gastrointestinal** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

**Respiratory** bronchospasm.

**Hematologic** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Miscellaneous** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

### ORAL

#### DOSEAGE AND ADMINISTRATION

**HYPERTENSION** - Dosage must be individualized. The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

#### PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

#### INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

#### OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

**BRADYCARDIA**—ADMINISTER ATROPINE (0.25 to 1.0 mg). IF THERE IS NO RESPONSE TO VAGAL BLOCKADE ADMINISTER ISOPROTERENOL CAUTIOUSLY.

**CARDIAC FAILURE**—DIGITALIZATION AND DIURETICS.

**HYPOTENSION**—VASOPRESSORS, e.g., LEVATERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

**BRONCHOSPASM**—ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

#### HOW SUPPLIED

TABLETS INDERAL (propranolol hydrochloride)

No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

#### INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as: 1 ml ampuls in boxes of 10.

Reference: 1. Freis, E. D. Hypertension (Suppl. II) 3: 230 (Nov.-Dec.) 1981.

7997/482

**Ayerst**

AYERST LABORATORIES  
New York, N.Y. 10017

# Abstracts of Action

April 15-18, 1982

Palmer House  
Chicago

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.*

## **EDS-FEDERAL, LIMITATIONS ON REIMBURSEMENT**

EDS-Federal, Medicare Part B intermediary in Illinois, recently reported that physicians would not be reimbursed for more than 24 visits per patient hospital stay. ISMS vigorously opposed this with resultant modification by EDS of this guideline. On recommendation by the Third Party Payment Processes Committee, the Board acted to seek further information from EDS regarding the manner by which the guideline was developed, the number of claims affected and the number of physicians affected.

## **IMPAIRED PHYSICIAN COMMITTEES**

Acting upon a recommendation of the Committee on Alcoholism and Drug Dependence, the Board voted to encourage all Illinois hospital medical staffs to establish a Committee for Impaired Physicians, utilizing ISMS guidelines for development of the activity. Copies of the guidelines will be available upon request to any member.

## **BC/BS OUTPATIENT PROCEDURES**

After thorough evaluation, the Council on Medical Services recommended General Criteria and Specific Procedural Guidelines relating to outpatient procedures covered by BC/BS for consideration by the Board. After review and comment the Board approved the General Criteria pertaining to ambulatory surgery. The Specific Procedural Recommendations, which indicate conditions which warrant consideration of inpatient care, were forwarded to BC/BS.

## **HOSPITAL HIGHWAY SIGN MARKERS**

The Illinois Department of Transportation plans to phase out the system of highway directional signs to Trauma Centers. Trauma signs will be replaced by markers identifying nearest hospital regardless of trauma capability. The Board directed communication to IDOT requesting delay of the new hospital highway sign program until appropriate opportunity for review and comment is provided to concerned citizens and groups which provide emergency medical care.

## **FIELD TEST JCAH STANDARDS**

Revised JCAH standards will be field tested in ten Illinois hospitals. The Board approved informational meetings, co-sponsored with the Illinois Hospital Association, for staffs of these hospitals, with the purpose to review and evaluate the revised standards.

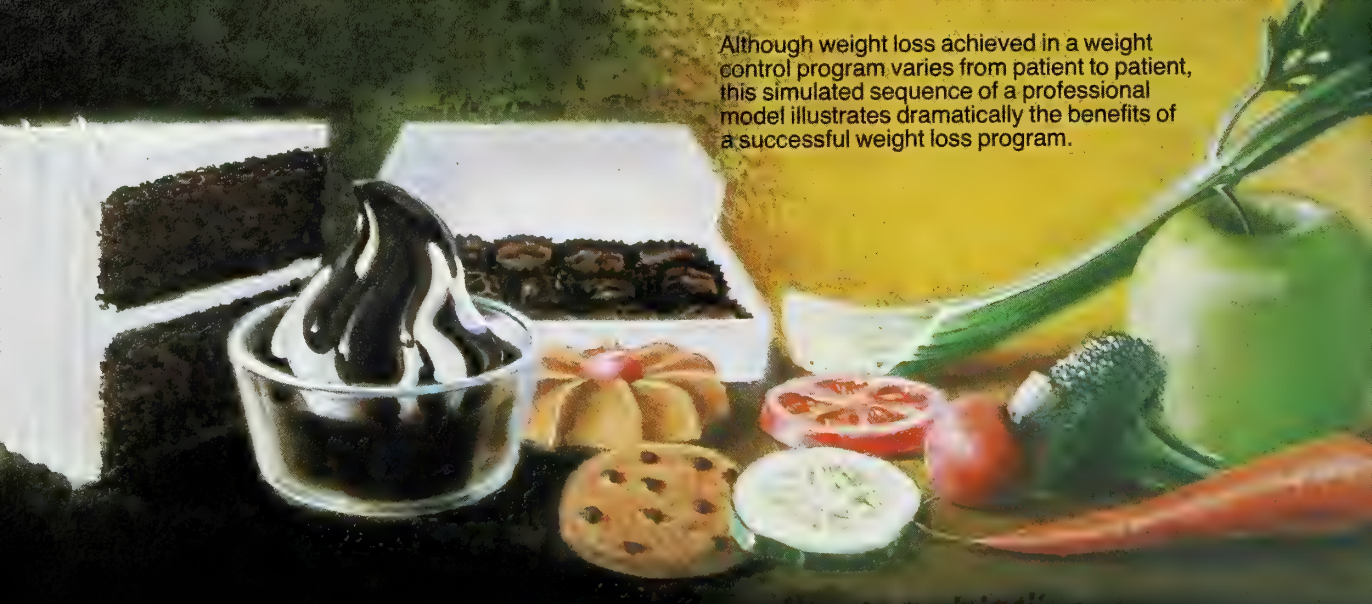
## **RETURN INJURED WORKER TO EMPLOYMENT**

As an aid to recovery and reducing costs in Workers Compensation cases, early return of workers to full or partial employment has been identified as effective. However, provisions of the Worker's Comp. law, which allow supplemental payments in cases of modified work schedules or assignments, are not fully utilized. The Board directed communication to the Illinois Industrial Commission

*(Continued on page 393)*



Although weight loss achieved in a weight control program varies from patient to patient, this simulated sequence of a professional model illustrates dramatically the benefits of a successful weight loss program.



getting there...

R<sub>x</sub> Potent Appetite Suppression

Tenuate<sup>\*</sup>

Dospan<sup>\*</sup>

IV

(diethylpropion hydrochloride USP)

75 mg controlled-release tablets

A useful short term adjunct  
in an overall weight loss program

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 17 separate double-blind, placebo controlled studies attest to its usefulness in daily practice.  
(Citations provided on request.)

Comparison of Anorectics

	Agent	Amine Classification	Half-life <sup>a</sup>	Variety of Dosage Form	Degree of CNS Effects
Low Abuse Potential	Diethylpropion	Tertiary	4-6 hrs.	25 mg tablet, 75 mg controlled-release tablet	Mild euphoria, mild stimulation
	Mazindol	Nonphenylethyl-amine	33-55 hrs.	1 & 2 mg tablet	Mild euphoria, mild stimulation
	Fenfluramine	Secondary	10-30 hrs.	20 mg tablet	Moderate sedation (mild to moderate depression, a side effect, is also sometimes designated as a CNS effect)
	Phentermine	Primary	19-24 hrs.	8 & 37.5 mg tablet, 8, 15 & 30 mg capsule, 15 & 30 mg capsule (resin complex), 15 & 30 mg timed release capsule	Mild euphoria, moderate stimulation
High Abuse Potential	Phenmetrazine	Secondary	7-9 hrs.	25 mg tablet, 50 & 75 mg prolonged action tablet	Marked euphoria, marked stimulation
	Amphetamine	Primary	10-30 hrs.	Various	Marked euphoria, marked stimulation

<sup>a</sup>Delayed release characteristics of certain dosage forms must also be taken into account.

The #1 prescribed anorectic

Merrell Dow



**Tenuate®<sup>IV</sup>**

(diethylpropion hydrochloride USP)

**Tenuate Dospan®<sup>IV</sup>**

(diethylpropion hydrochloride USP)

controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

**INDICATION:** Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

**CONTRAINDICATIONS:** Advanced arteriosclerosis; hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines; glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

**WARNINGS:** If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

**PRECAUTIONS:** Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

**ADVERSE REACTIONS:** *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

**DOSAGE AND ADMINISTRATION:** Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in the evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in the midmorning. Tenuate is not recommended for use in children under 12 years of age.

**OVERDOSAGE:** Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

**Reference:** 1. Abramson R, Garg M, Cioffari A, and Rotman PA; An Evaluation of Behavioral Techniques Reinforced with an Anorectic Drug in a Double-Blind Weight Loss Study. *J Clin Psych* 41:234-237, 1980.

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MERRELL-NATIONAL LABORATORIES Inc.  
Cayey, Puerto Rico 00633

Direct Medical Inquiries to



MERRELL DOW PHARMACEUTICALS INC  
Subsidiary of The Dow Chemical Company  
Cincinnati, Ohio 45215, U S A

**Merrell Dow**

1-8515 (Y683C) MNQ-060

## Obituaries

**Aimone, John A.,** Berwyn, died March 16, 1982 at the age of 62.

**\*Barwasser, Norbery C.,** Moline, died May 11, 1982 at the age of 78. Dr. Barwasser was a 1934 graduate of the Rush Medical College, Chicago.

**\*\*Blair, Earl H.,** Sun City, Arizona, died May 13, 1982 at the age of 80. Dr. Blair was a 1927 graduate of the Ohio State University College of Medicine, Columbus.

**\*\*Bogue, Arthur R.,** Tilton Park, died March 13, 1982 at the age of 86. Dr. Bogue was a 1920 graduate of the University of Illinois School of Medicine, Chicago.

**\*Horodylowsky, George,** Chicago, died March 18, 1982 at the age of 60. Dr. Horodylowsky was a 1949 graduate of the Medizinische Fakultät der Universität Edangen, Erlangen, Bayem.

**\*Lowy, Howard A.,** E. Peoria, died April 30, 1982 at the age of 68. Dr. Lowy was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

**\*\*McCarthy, John D.,** Riverside, died April 18, 1982 at the age of 82. Dr. McCarthy was a 1932 graduate of Rush Medical College, Chicago.

**\*\*Neiman, Aaron,** Riverdale, New Jersey, died March 27, 1982 at the age of 84. Dr. Neiman was a 1926 graduate of the University of Illinois College of Medicine, Chicago.

**\*\*Passarelli, Edwin A.,** Chicago, died May 4, 1982 at the age of 73. Dr. Passarelli was a 1932 graduate of Georgetown University School of Medicine, Washington.

**Pfeifer, James M.,** Cincinnati, Ohio, died March 9, 1982 at the age of 73. Dr. Pfeifer was a 1934 graduate of the Indiana University School of Medicine, Indianapolis.

**Rosen, Kenneth M.,** Chicago, died March 6, 1982 at the age of 44.

**\*\*Strauss, Herman A.,** Chicago, died May 5, 1982 at the age of 77. Dr. Strauss was a 1932 graduate of the Northwestern University Medical School, Chicago.

**\*Wagner, Hans H.,** Oak Lawn, died April 13, 1982 at the age of 62. Dr. Wagner was a 1950 graduate of the Medizinische Fakultät der Johann-Wolfgang Goethe Universität, Frankfurt Am Main, Hessen.

*\*Indicates ISMS Member*

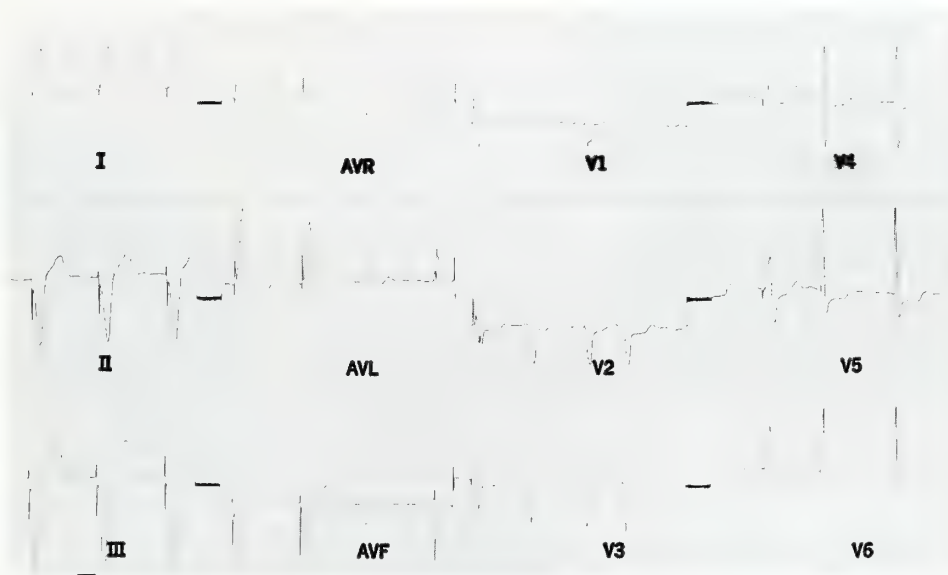
*\*\*Indicates member of the ISMS Fifty Year Club*

*Illinois Medical Journal*

# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a seventy-three year old woman who complains of chest pains and dyspnea. Her cardiac history started in 1973 with a myocardial infarction. In 1976, she developed paroxysmal atrial fibrillation. This progressed to a bradycardia-tachycardia syndrome, and a demand pacemaker was required in 1979. The patient complained of intermittent problems caused by "water on her lungs," since 1980. She thought this was occurring again and causing shortness of breath. She had a blood pressure of 144/84 mmHg and an irregular pulse of 84 beats per minute. The jugular venous pressure was increased and crepitant rales were present in both lung bases. The cardiac exam demonstrated a grade 3/6 apical holosystolic murmur and a ventricular gallop. A chest X-ray confirmed the impression of cardiomegaly. A twelve lead ECG was obtained and is shown.*



## Questions:

### 1. The twelve lead ECG shows:

- An accelerated idioventricular rhythm.
- A well functioning demand pacemaker.
- Atrial fibrillation with high grade or advanced atrioventricular rhythm.
- An old anteroseptal wall myocardial infarction.
- All of the above.

### 2. The following statement(s) is/are true:

- The clinical presentation of this patient is compatible with congestive heart failure.
- The clinical history is compatible with pacemaker failure.
- Management of this patient's problem would include digitalis and diuretics.
- The ST-T waves of the conducted beats could be caused by digitalis and ischemia.
- All of the above.

(Continued on page 396)



**BECAUSE  
A THIAZIDE ALONE  
CAN ONLY DO  
SO MUCH...**

**AND YET  
CAN DO  
TOO MUCH.**



# INCREASE CONTROL WITHOUT INCREASING POTASSIUM PROBLEMS.

## **A dependable means to long-term blood pressure control.**

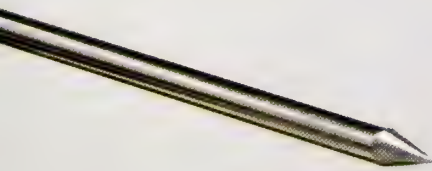
Many times, a diuretic alone can't keep hypertension in check. *INDERIDE*, however, can pick up where thiazide therapy leaves off.

The combination of propranolol HCl, the world's most trusted beta blocker, and hydrochlorothiazide, the standard among diuretics, enables *INDERIDE* to exert an additive antihypertensive effect.<sup>1,2</sup> In fact, a propranolol/hydrochlorothiazide regimen maintained blood pressure below 90 mm Hg in 81.8% to 86.4% of patients followed for 6 to 18 months of therapy.<sup>1</sup>

## **Low thiazide dosage means reduced risk of hypokalemia.**

When thiazides are prescribed in doses greater than 50 mg/day, the potential for hypokalemia increases substantially. What's more, the greater the fall in serum K<sup>+</sup>, the greater the risk of hypokalemia-induced PVCs.<sup>3,4</sup>

With *INDERIDE*, the additive hypotensive effect of propranolol HCl allows the effective dose of hydrochlorothiazide to be kept low (25 mg b.i.d.). And by lowering the daily dose of diuretic, *INDERIDE* also lowers the potential for diuretic-induced side effects. Potassium problems are less likely to occur—yet blood pressure can be controlled consistently.



# **INDERIDE<sup>®</sup>**

Each tablet contains *INDERAL<sup>®</sup>* (propranolol HCl) 40 mg or 80 mg, and hydrochlorothiazide 25 mg | **B.I.D. 40/25  
80/25**

## **When you know you need more than a thiazide.**

Please see Brief Summary of Prescribing Information on following page.



BRIEF SUMMARY  
(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

## INDERIDE®

BRAND OF  
propranolol hydrochloride  
(INDERAL®)  
and hydrochlorothiazide

No. 474—Each IINDERIDE®-40/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	40 mg
Hydrochlorothiazide	25 mg
No. 476—Each IINDERIDE®-80/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	80 mg
Hydrochlorothiazide	25 mg

**WARNING:** This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

**DESCRIPTION:** IINDERIDE combines two antihypertensive agents: IINDERAL (propranolol hydrochloride), a beta-adrenergic blocking agent, and hydrochlorothiazide, a thiazide diuretic-antihypertensive.

**INDICATION:** IINDERIDE is indicated in the management of hypertension. (See boxed warning.)

**CONTRAINDICATIONS:** **Propranolol hydrochloride (INDERAL®):** Propranolol hydrochloride is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

**Hydrochlorothiazide:** Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

**WARNINGS:** **Propranolol hydrochloride (INDERAL®):** CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

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IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA:** Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

**USE IN PREGNANCY:** **Propranolol hydrochloride (INDERAL®):** The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

**Hydrochlorothiazide:** Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**Nursing Mothers:** Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

**PRECAUTIONS:** **Propranolol hydrochloride (INDERAL®):** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

**Hydrochlorothiazide:** Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may be a fluence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular rigidity, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients receiving prolonged thiazide therapy. The common complications of hyperparathyroidism such as: bone resorption, bone pain, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

**ADVERSE REACTIONS:** **Propranolol hydrochloride (INDERAL®):** Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesias of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

**Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation of time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

**Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with arthralgia and sore throat, laryngospasm and respiratory distress.

**Respiratory:** bronchospasm.

**Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe liver disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**Hydrochlorothiazide:** **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

**Central Nervous System:** dizziness, vertigo, paresthesias, headache, xanthopsia.

**Hematologic:** leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

**Cardiovascular:** orthostatic hypotension (may be aggravated by alcohol, barbiturate, narcotics).

**Hypersensitivity:** purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculocutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reaction.

**Other:** hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

**DOSEAGE AND ADMINISTRATION:** The dosage must be determined by individual titration (see boxed warning).

Hydrochlorothiazide is usually given at a dose of 50 to 100 mg per day. The initial dose of propranolol is 40 mg twice daily and it may be increased gradually until optimum blood pressure control is achieved. The usual effective dose is 160 to 480 mg per day.

One to two IINDERIDE tablets twice daily can be used to administer up to 320 mg of propranolol and 100 mg of hydrochlorothiazide. For doses of propranolol greater than 320 mg the combination products are not appropriate because their use would lead to an exact dose of the thiazide component.

When necessary, another antihypertensive agent may be added gradually beginning 50 percent of the usual recommended starting dose to avoid an excessive fall in blood pressure.

**OVERDOSEAGE OR EXAGGERATED RESPONSE:** The propranolol hydrochloride (INDERAL) component may cause bradycardia, cardiac failure, hypotension, or bronchospasm.

The hydrochlorothiazide component can be expected to cause diuresis. Lethargy or drowsiness may appear and may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function, and in the absence of significant serum electrolyte changes or dehydration. The mechanism of central nervous system depression with thiazide overdosage is unknown. Gastrointestinal irritation and hypermotility can temporarily elevate of BUN has been reported, and serum electrolyte changes could especially in patients with impairment of renal function.

**TREATMENT:** The following measures should be employed: **GENERAL:**—If ingestion is suspected, induce emesis, evacuate gastric contents taking care to prevent pulmonary aspiration. **BRADYCARDIA:**—Administer atropine (0.25 to 1.0 mg). If there is no response to atropine, administer isoproterenol cautiously. **CARDIAC FAILURE:**—Digitalization and diuretics. **HYPOTENSION:**—Vasopressors, e.g., levaterenol or epinephrine. **BRONCHOSPASM:**—Administer isoproterenol and aminophylline. **STUPOR OR COMA:**—Administer supportive therapy as clinically warranted. **GASTROINTESTINAL EFFECTS:**—Though usually of short duration, these may require symptomatic treatment. **ABNORMALITIES IN AND/OR SERUM ELECTROLYTES:**—Monitor serum electrolyte levels and renal function; institute supportive measures as required individually to maintain hydration, electrolyte balance, respiration, and cardiovascular-renal function.

**HOW SUPPLIED:** No. 474—Each IINDERIDE®-40/25 tablet contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000, unit dose package of 100.

No. 476—Each IINDERIDE®-80/25 tablet contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

**References:** 1. Veterans Administration Cooperative Study Group on Antihypertensive Agents: J. A. M. A. 237:2303 (May 23) 1977; 2. Bravo, E. L., Tarazi, R. C., and Dustan, H. P. N. Engl. J. Med. 292:66 (Jan. 9) 1975; 3. Hollifield, J. W., and Slaton, P. E.: Acta Med. Scand. [Suppl.] 647:67, 1981; 4. Holland, O. B., Nixon, J. V., and Kuhnert, L.: Am. J. Med. 70:762 (Apr.) 1981.

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# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This month's viewbox was prepared by David Okrent, M.D. and Terrence C. Demos, M.D., Department of Radiology, Loyola University Stritch School of Medicine, Maywood.*



**Figure 1**

Supine radiograph of the abdomen. This 45 year old man has a chronic gastrointestinal problem. He came to the emergency room with abdominal distention and pain.



**Figure 2**

Supine radiograph of the abdomen. Plain film of the abdomen in a patient with the light chain type of multiple myeloma. He has had abdominal distention and episodes of diarrhea for several months.

**Figures 3 and 4**



**Figure 3**

Supine radiograph of the abdomen.



**Figure 4**

Left lateral decubitus of abdomen with vertical X-ray beam. This patient suffers from migraine headaches. Recently he had a "spell" and took codeine frequently to relieve his discomfort. He now has a distended abdomen.

**Match the following diagnoses with the three patients above:**

1. mechanical colon obstruction
2. amyloidosis
3. scleroderma
4. analgesic associated pseudo-obstruction
5. toxic megacolon

*(Continued on page 435)*



One of nature's  
most predictable modalities...



*Alopex lagopus*

## THE ARCTIC FOX

The arctic fox is nature's turncoat. This small, curious animal, only about 2 feet long, lives on the barren tundra above the northern boundaries of tree growth. Because it neither migrates nor hibernates during the winter months, it is equipped with a very special kind of "reversible coat" that permits year-round habitation.

Like clockwork, the fox's gray-brown fur turns completely white as the winter solstice approaches, and then returns to its normal color during the spring thaw. The fox's coat also undergoes a smoky blue phase. This cyclical camouflage enables the fox to blend readily with the changing scenery of its environment, masking it from predators and prey.

The arctic fox: an animal whose coat is always in season. Few animals in nature have such a predictable pattern of adaptability.

In medicine, few drugs can match the predictable pattern of therapeutic action that you can expect with Librium. Well known for its safety, Librium provides prompt, effective relief of anxiety disorders and symptoms. At recommended doses it has virtually no effect on either the cardiovascular or the respiratory system, and rarely affects mental acuity. As with any drug in its class, patients should be cautioned about driving, operating hazardous machinery or drinking alcohol while on Librium therapy.

Librium. A natural selection for your clinically anxious patients.



For the treatment of anxiety

# Librium® chlordiazepoxide HCl/Roche

5 mg, 10 mg, 25 mg capsules

## one of man's



**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Known hypersensitivity to drug.  
**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. **Oral—Adults:** Mild and moderate anxiety disorders and symptoms, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. **Geriatric patients:** 5 mg b.i.d. to q.i.d. (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl/Roche) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50. Libritabs® (chlordiazepoxide/Roche) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

## Clinics for Crippled Children Listed for July

Forty-two clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 28 general clinics, 10 cardiac clinics, two for children with myelodysplasia, one for children with neurological problems, and one for children with scoliosis. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- 1 Springfield General - Memorial Med. Bldg.
- 1 Sterling - Community General Hospital
- 1 Effingham - St. Anthony Memorial Hospital
- 1 Hinsdale - Hinsdale Sanitarium
- 1 Lake County Cardiac - Victory Mem. Hosp.
- 2 Division Cardiac - U. of I. at the Medical Center
- 6 Danville - Lakeview Hospital
- 6 Park Ridge General - PM - Lutheran General Hospital
- 6 Park Ridge Cardiac - AM - Lutheran General Hospital
- 8 Aurora Cardiac - Mercy Center for Health Care Services
- 8 Kankakee General - St. Mary's Hospital
- 9 Hinsdale Scoliosis - Hinsdale Sanitarium
- 12 Belleville - St. Elizabeth Hospital
- 12 Peoria Myelodysplasia - St. Francis Medical Center
- 12 Maywood (Ortho/Ped/Neuro) Loyola Medical Center
- 12 Chicago Heights Cardiac - St. James Hosp.
- 13 East St. Louis - Community Hospital
- 13 Quincy - St. Mary's Hospital
- 13 Peoria General - St. Francis Med. Ctr.
- 14 Champaign-Urbana - McKinley Health Service Center
- 14 Joliet - St. Joseph's Hospital
- 14 Chicago Heights General - St. James Hosp.
- 15 DuQuoin - Marshall Browning Hospital
- 15 Centralia - St. Mary's Hospital
- 15 Elmhurst Cardiac - Memorial Hospital of DuPage County
- 16 Kankakee Cardiac - St. Mary's Hospital
- 19 Peoria Cardiac - St. Francis Med. Center
- 19 Maywood (Ortho/Ped) - Loyola Med. Ctr.
- 20 Rock Island General and CP - Moline Public Hospital
- 20 Decatur - Decatur Memorial Hospital
- 20 Alton - Alton Memorial Hospital
- 21 Springfield Ped-Neuro - Memorial Med. Bldg.
- 21 Rockford - St. Anthony Hospital
- 21 Aurora MM - Mercy Center for Health Care Services
- 21 Evergreen Park - Little Company of Mary Hospital
- 22 Champaign Children's Home - Champaign
- 26 Peoria Cardiac - St. Francis Med. Center
- 26 Chicago Heights Cardiac - St. James Hosp.
- 27 Peoria General - St. Francis Medical Ctr.
- 28 Elgin - Sherman Hospital
- 28 Chicago Heights General - St. James Hosp.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



Roche Products Inc.  
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# Abstracts of Board Actions

*(Continued from page 381)*

indicating support and encouragement of (1) Greater implementation of the law allowing supplemental disability income for workers in modified work programs; and (2) Prompt placement of injured workers in positions allowing limited activity level, as appropriate.

In a related matter, the Board agreed that after educational seminars in 1983, ISMS will work with county medical societies to encourage participation in review of workers compensation cases, and to transmit information to the insurance industry on the peer review process in workers compensation.

## LABORATORY SERVICES

After reviewing time requirements for laboratory measurements in the Hospital Licensing Act rules, related to maternal and neonatal services, the Board directed a communication to IDPH indicating that: (1) There is a lack of realistic time specification in some laboratory requirements; and (2) There is a need for written interpretation of the laboratory measurements as contained in the Rules.

## HEALTH PLANNING

Agreeing with its Committee on Health Planning, which reflected serious misgivings about legislating new programs to enable health planning in Illinois, the Board voted to oppose existing proposals to create new regulatory health planning programs administered by the state. Opposition also would be expressed to any state planning program calling for governing board structures similar to current HSAs. A position paper on Alternative Proposals for Health Planning was accepted and endorsed.

In a related matter, the Board authorized introduction of a House of Delegates resolution which would establish ISMS policy in opposition to extension of HSA activity, in support of voluntary, local health planning, and holding forth the principle that state regulation inhibits the voluntary nature of planning and such regulation, if any, should be independent of the planning process.

## LEGISLATION

In review of various legislative proposals currently before the General Assembly, the Board revised the primary list of bills, and addressed specifically:

- Support of HB 1296 (to prohibit local assessors from reassessing previously classified items of personal property as real estate).
- Support, if properly amended, SB 1492 (amending the Radiation Protection Act, as it relates to radiologic technicians).
- Amendment of HB 662 to include prohibition against independent practice by nurses.
- Development of an amendment to the Mental Health Confidentiality Act to allow limited access to specific information under tightly controlled circumstances. The Board action follows a recent court case in Springfield in which a psychiatric nurse, citing the Act, refused to provide local police with the identity of a patient overheard to claim he had committed an axe murder.

## INJECTIONS BY NON-LICENSED PERSONNEL

After study by the Council on Medical Services and the Medical Legal Council, a report was reviewed by the Board relating to the authority of a physician to delegate routine tasks, specifically injections, to non-licensed personnel in the office setting. In keeping with previous ISMS positions, the Board directed a letter to the Department of Registration and Education, encouraging promulgation of a regulation allowing that "In a non-hospital setting, a physician may delegate the administration of an injection by a person the physician has determined is qualified to administer such an injection. The physician shall supervise and be responsible for the acts of this person."



## **DR. FRANK JIRKA CANDIDACY FOR AMA PRESIDENT-ELECT**

The AMA Delegation and the Board of Trustees evidenced unanimous support for the candidacy of Frank Jirka, Jr., M.D., to be president-elect of the AMA. Dr. Dan Cloud, Arizona, current president of the AMA, attended the Board meetings and later addressed the House of Delegates. A peer-to-peer campaign was initiated, by which all members of the Board, the Delegation and the House of Delegates were encouraged to call and write members of the AMA House of Delegates in support of Dr. Jirka.

## **IDPA DRUG MANUAL**

The Board approved the following drugs for inclusion in the IDPA Drug Manual: Lidex (Fluocinnide), Lidex-E (Fluocinnide), Topsy (Fluocinnide), Metaproterenol Sulfate Tab. Syrup, Procardia (Nifedepine), Timolide Actified (Triopolidine Pseudophedrine), and Zovirax (Acyclosir). In addition, some 96 preparations were agreed upon for removal from the manual, based upon evaluation of other preparations available and costs.

In a related action, the Board rejected a proposal that Valium require a triplicate prescription.

## **ELECTION OF CHAIRMAN**

Warren D. Tuttle, M.D., was elected chairman of the board, at the closing session. He presented a parting gift to retiring chairman, Morris T. Friedell, M.D., Chicago. Introduced to the Board were two newly-elected members, Richard Blankshain, M.D., Oak Park (3rd District) and Arthur Traugott, M.D., Champaign (8th District). Certificates of appreciation were presented officers and trustees in recognition of their contributions to the Society during their terms of office.

## **OTHER ACTIONS**

In other actions, the Board:

- Endorsed a resolution to allow redirection of one-half the AMA-ERF funds (\$5.00) from dues paying members, to a student financial assistance program in the ISMS Educational and Scientific Foundation.
- Supported continuation of the triplicate prescription system for designated products, contingent upon continuing dialogue with state agencies.
- Approved applying for renewal of a grant from IDMHDD to support alcoholism education.
- Granted probationary CME accreditation of one year to a hospital appealing removal of accredited status.
- Approved an Old Business Report to the House urging rejection of Resolution 29 (A-81) which called for elimination of mandated pre-marital testing for syphilis.
- Authorized initiation of discussions with IDPH to review pre-marital examinations, testing, and alternatives.
- Endorsed Cancer Surveillance Pilot Projects of the Illinois Cancer Council.
- Approved ISMS participation in expanded review of protocols under the IDPH Maternal Mortality Reporting System, for 1982-83, contingent upon IDPH funding of increased meeting activity.
- Requested legal counsel review of the premise under which employers or insurers encourage patients not to pay physician fees which exceed the amount covered by a third party, and in which the third party holds the patient harmless and will defend against a physician seeking to recover his full fee.
- Approved publication of a brochure on HMO/IPA.
- Referred back to the Council on Economics a proposed paper on Consumer Choice/Pro-Competition legislation.

- Voted to publish notice of the availability of an AMA brochure entitled "Let's Talk About Health Insurance," and encourage physicians to obtain copies for their patients.
- Agreed to work with the Illinois Nurses Association to write rules for the Nurse Practice Act to include prohibition of independent nurse practice.
- Strongly opposed efforts by the Department of Registration and Education to modify current law to allow use of hospital peer review records for purposes of bringing discipline against a license.
- Directed support of the Potawatomi Festival (Indiana) nomination of Dr. John Evans for a commemorative U.S. Postal Stamp.
- Authorized the Medical-Legal Council to submit articles on medical-legal topics for consideration by the *IMJ* Editorial Board.
- Using the Council on Education responses to a Board of Higher Education survey on Illinois medical education, agreed to respond to the BHE request for input into a report on physician distribution, retention, loans, and education being developed.
- Requested that the ISMIS Board of Directors consider existing mechanisms of financial control, with outside review, if necessary, and report back to the Board at its September meeting.
- Nominated for the ISMIS Board of Directors, 1982-83, Phillip Boren, M.D., Carmi; Alfred Clementi, M.D., Arlington Heights; Robert Hamilton, M.D., Chicago; Jerry Ingalls, M.D., Paris; Clifton Reeder, M.D., Chicago; Warren Tuttle, M.D., Harrisburg.

## PROGRAMS

The Board authorized the following program activities:

- Rescheduling the Annual Alcoholism Program to May 26, 1982, so it will be held in conjunction with the Illinois Institute on Drug Abuse program in Peoria. Emphasis will be on mixed addictions.
- Development of a program on Worker's Compensation law for the 1983 Midwest Clinical Conference.

## COMMITTEES

The Board voted to assign responsibility for:

- Ongoing negotiations with Blue Cross/Blue Shield to the Committee on Third Party Payment Processes
- Monitoring coalitions to the Committee on Health Planning

## APPOINTMENTS

The following appointments and nominations were made:

- Homer Parkhill, M.D., Pontiac, as a member of the ISMS Panel for the Impaired Physician.
- Nomination of Donald M. Sherline, M.D., Chicago, as representative to the IDPH Nutrition Services Advisory Committee
- Nominated for the IDPA State Medical Advisory Committee, Drs. Randolph Emerson, Decatur, Charles Frazer, East St. Louis, Paul Norris, Peoria, Pedro Poma, Melrose Park, and Hugo Velarde, Chicago.
- Nomination of Samuel Andelman, M.D., Skokie, as Medical Coordinator for the Department of Registration and Education.
- Alfred Kiessel, M.D., Decatur, Finance Committee Chairman, 1982-83.
- Lawrence Hirsch, M.D., Chicago, Policy Committee Chairman, 1982-83.
- Alexander Lerner, as proxy for the shareholder, ISMS, at the May 5, 1982 annual meeting of Illinois State Medical Insurance Services, Inc.



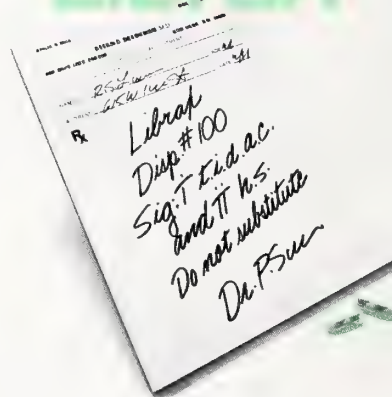
## EKG

(Continued from page 385)

Answers: 1. B,C,D. 2. A,C,D.

The twelve lead ECG shows a well functioning demand pacemaker best seen in leads I, II, III. Atrial fibrillation with high grade atrioventricular block is present. Conducted beats with poor R wave progression and ST segment depression are present in leads  $V_1V_2V_3$ . The poor R wave progression suggests an anteroseptal myocardial infarction that is old. Her clinical presentation was that of congestive heart failure. It was complicated because she was already taking a digitalis preparation and her atrioventricular block prevented a marked increase in her heart rate. Her dose of digitalis was increased and diuretics were added with good result. A nuclear medicine multigated acquisition scan (MUGA) showed moderate hemodynamic impairment with an ejection fraction of 39%. An echocardiogram demonstrated right and left ventricular and left atrial enlargement as well as a small pericardial effusion. The ST segment depression and T waves seen in the precordial leads only in the conducted beats from the atrial fibrillation are compatible with ischemic heart disease and digitalis. Our patient improved with the increased doses of digitalis and diuretics. ◀

Specify  
Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:  
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.  
Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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**References:** 1. Sullivan MA, Cohen S, Snape WJ. *N Engl J Med* 298:878-883, Apr 20, 1978.  
2. Snape WJ et al. *Gastroenterology* 72: 383-387, Mar 1977.

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In 1981, new boundaries were drawn for the 59 senate districts and the 118 new single-member House districts (as provided by the 1980 cut-back amendment).

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This year we will be asking auxiliaries to get involved in bumper stickers campaigns, telephoning, polling, etc., simple, but effective measures to help candidates for public office. A phrase of David Durenberger, Republican Senator from Minnesota, reflects my feelings in this area: "I tend to simplify things because I don't have time to complicate them." We intend to keep our involvement in the legislative arena simple, but effective.

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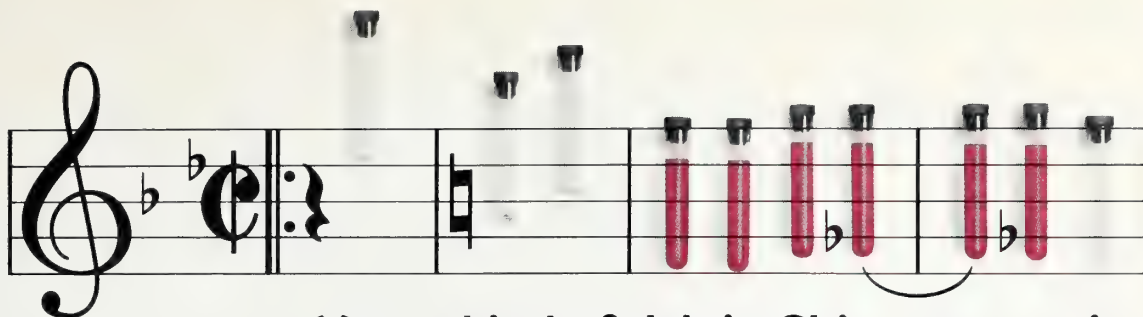


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namely hyponatremia, hyponatremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hyponatremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hyponatremic alkalosis, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

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# Illinois Society, American Association of Medical Assistants

## The Triton College Medical Assisting Program

BY LESA GREENE, CMA-C

There are several medical assisting programs in Illinois accredited by the Committee on Allied Health Education and Accreditation.

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Twenty-five to thirty full-time students are admitted each fall to this two-year medical assisting program. Students in this program enroll in courses ranging from anatomy and physiology to

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For further information regarding this program, contact Lesa Greene, CMA-C, coordinator, Medical Assisting Program, 312-456-0300, extension 293. Written communication may be directed to Triton College, 2000 Fifth Avenue, River Grove, IL 60171.

Information regarding Illinois Society, AAMA may be obtained from Janet Binkowski, RN, President, Illinois Society, 428 Adams, Dolton, IL 60419. ◀



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# I M J

*Illinois Medical Journal*

Volume 161, No. 6, June 1982

## Small Bowel Obstruction As A Sequel To Fitz-Hugh/Curtis Syndrome

BY ALFRED N. ROSSI, M.D., COLATHUR K. PALANI, M.D. AND  
OLGA JONASSON, M.D./HOPEDALE AND CHICAGO

*The perihepatic "Violin-String" adhesions formed secondary to Fitz-Hugh/Curtis Syndrome are usually inconsequential. Recently, we encountered two patients in their fifties who developed closed-loop small bowel obstruction secondary to these adhesions. With the increased incidence of pelvic inflammatory disease since 1960, this complication may come to be encountered more frequently.*

Perihepatitis resulting from gonococcal pelvic inflammatory disease was first described in 1920 by Stejano<sup>1</sup> who reported a subphrenic reaction

to a pelvic inflammatory process. Fitz-Hugh<sup>2</sup> and Curtis<sup>3</sup> subsequently elaborated on the "Violin-String" adhesions which develop between the liver, diaphragm and parietes secondary to gonococcal pelvic peritonitis. The syndrome of gonococcal perihepatitis now bears the eponym, Fitz-Hugh/Curtis Syndrome. In a recent review of 124 cases of pelvic inflammatory disease, (P.I.D.) Semchyshyn<sup>4</sup> documented a 12.1% incidence of Fitz-Hugh/Curtis Syndrome. The acute phase of perihepatitis may be mistaken for acute cholecystitis. The late "Violin-String" adhesions do not usually lead to serious sequelae and are encountered at surgery as incidental findings. We have recently encountered two patients with mechanical small bowel obstruction secondary to these "Violin-String" adhesions. The purpose of this report is to describe the clinical presentation of these two patients and discuss the diagnostic and therapeutic implications.

---

**OLGA JONASSON, M.D.**, is a board certified surgeon and chief of surgery at Cook County Hospital in Chicago. A professor of surgery at the UI College of Medicine, Dr. Jonasson cites particular interest in transplant surgery.

**COLATHUR K. PALANI, M.D.**, is a board certified attending surgeon at Cook County Hospital in Chicago. An assistant professor of surgery at the UI College of Medicine, Dr. Palani has served as chairman of the surgical UGI Endoscopy Service and chief of the Hyperalimentation Team at Cook County Hospital.

**ALFRED N. ROSSI, M.D.**, is a board certified surgeon affiliated with Hopedale Hospital in Hopedale, Illinois. He is both chief of staff and chairman of the department of surgery at the Hopedale Medical Complex.





**Figure 1**  
Lateral chest X-ray of Case #1 with dilated loop of small intestine (arrow) anterior to right lobe of the liver.

## Case Reports

**Case #1:** A 54-year-old female presented to Cook County Hospital with a seven day history of intermittent cramping, abdominal pain, nausea and vomiting. There was no history of surgery, weight loss or change in bowel habits. Physical examination revealed a well nourished patient with moderate dehydration. Vital signs were normal except for a temperature of 37.2°C.

The abdomen was minimally distended and non-tender, with infrequent high pitched bowel sounds. Neither herniae nor abdominal scars were present. Routine laboratory tests were normal. Roentgenograms of the chest and abdomen showed a complete high small bowel obstruction with a loop of small bowel anterior to the liver, seen on the lateral chest film (Figure 1). At laparotomy multiple "Violin-String" adhesions were found between the liver and the diaphragm. A



**Figure 2**  
Intraoperative photograph of Case #1 showing "Violin-String" adhesions (arrow) between the right lobe of the liver (L) and diaphragm, with incarcerated small bowel.

loop of jejunum had herniated between two of these adhesions which were thickened and cord-like (Figure 2). Adhesions suggestive of previous inflammatory disease were also found in the pelvis. All adhesions were lysed and the patient made an uneventful recovery. Upon further questioning in the postoperative period, the patient recalled having pelvic inflammatory disease 15 years prior to admission, although she denied right upper quadrant symptoms with that episode.

**Case #2:** A 58-year-old female presented to Cook County Hospital with a case history of vomiting for one week and cramping abdominal pain for three days. She had been obstipated for 36 hours. There was no history of previous abdominal surgery, weight loss or changes in bowel habits. Physical examination revealed a well nourished patient with normal vital signs except for a temperature of 37.4°C. The abdomen was distended and tympanic without surgical scars or herniae. Palpation revealed no area of tenderness and auscultation revealed hyperactive high pitched bowel sounds.

Laboratory tests were normal except for a serum sodium of 126mEq/L and serum potassium of 2.8mEq/L. Chest and abdominal roentgenograms revealed evidence of complete small bowel obstruction. Following correction of electrolyte abnormalities, the patient underwent an exploratory laparotomy. A loop of mid-ileum was found firmly entrapped between several "Violin-String" adhesions above the right lobe of the liver causing complete obstruction to the lumen. Multiple adhesions were noted in the pelvis and were probably secondary to previous pelvic inflam-

matory disease. The patient denied any past history of pelvic inflammatory disease or symptoms suggestive of Fitz-Hugh/Curtis Syndrome.

### Comments

Intra-abdominal adhesion as a consequence of previous laparotomy is the leading cause of small bowel obstruction. Adhesions may also occur in the absence of previous abdominal surgery. Raf<sup>5</sup> reviewed the records of 1477 patients with adhesive small bowel obstruction and found that 184 patients (14%) had no antecedent laparotomy. Pelvic adhesions from previous inflammatory disease were the cause of obstruction in 26 of these 184 patients (14%). Aho and Gronroos<sup>6</sup> reported that 9.5% of 252 intestinal obstructions in females were secondary to pelvic adhesions.

Curtis<sup>3</sup>, in his original description of 12 patients with "Violin-String" adhesions between the liver and parietes, described these adhesions as numerous and of sufficient length to allow mobility of the liver away from parietal peritoneum. While these adhesions are usually flimsy and harmless, our two patients illustrate the fact that they may cause closed loop intestinal obstruction even after a long latent period following gonococcal pelvic peritonitis.

Closed loop intestinal obstruction is associated with a mortality rate as high as 30%.<sup>7</sup> Early diagnosis and surgical treatment are important factors in minimizing this mortality. The plain chest roentgenogram in one of our patients demonstrated the herniated loop of small bowel anterior and superior to the right lobe of the liver (Chilaiditis Sign).<sup>8</sup> This radiographic sign in a female patient with small bowel obstruction and no abdominal scars should suggest a diagnosis of closed loop obstruction secondary to Fitz-Hugh/Curtis Syndrome and lead to prompt surgery.

While PID is a disease affecting young women in their twenties, both of our patients were in their fifties. The reason for this long latent period is not clear. The incidence of gonococcal disease has increased in the United States since the early 1960s.<sup>9</sup> Moreover, the incidence of non-gonococcal venereal disease and pelvic peritonitis is increasing and there is recent evidence to suggest that Chlamydia trachomatis pelvic peritonitis may be associated with a higher incidence of Fitz-Hugh/Curtis Syndrome.<sup>10</sup>

It is possible that mechanical small bowel obstruction secondary to "Violin-String" adhesions will be encountered more frequently in the future. This entity should be considered in a female patient with bowel obstruction and no prior abdominal surgery. Chilaiditis' sign (a distended loop of small bowel seen on lateral chest Xray

to be anterior to the liver) may be useful in making the diagnosis. ◀

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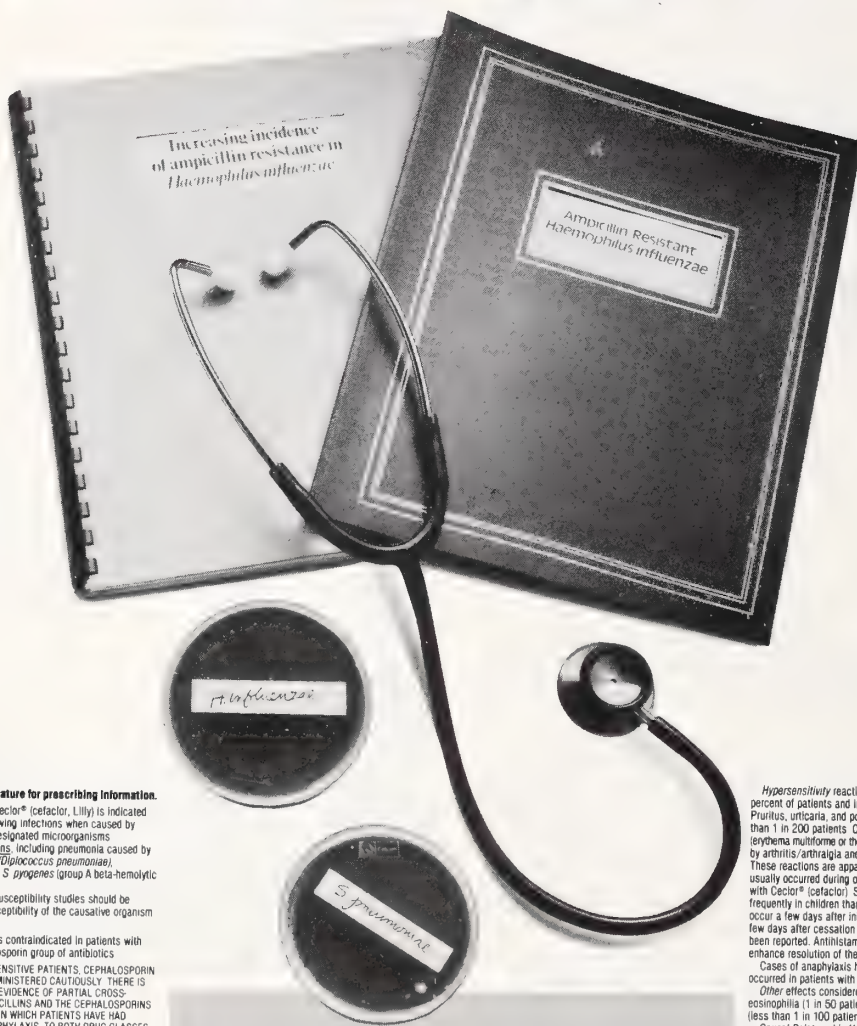
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**Contraindication:** Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

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Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

**Usage in Pregnancy:** Although no teratogenic or antileptile effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

**Usage in Infancy:** Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** Adverse effects considered related to cefclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefclor.

**Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Cefclor.<sup>1-6</sup>**

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.<sup>7</sup>

# Cefclor®

## cefclor

Pulvules®, 250 and 500 mg

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor® (cefclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy. Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship Uncertain:** Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Hepatic:** Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Hematopoietic:** Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

**Renal:** Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(1002819)

\*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

**Note:** Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

## References

1. Antimicrob. Agents Chemother., 8:91, 1975.
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6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from  
Eli Lilly and Company  
Indianapolis, Indiana 46285  
Eli Lilly Industries, Inc.  
Carolina, Puerto Rico 00630



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1982 Annual Meeting  
ISMS House of Delegates  
New Officers and Trustees  
Highlights  
Summary of Actions



# Illinois State Medical Society

## 1982-83 Board of Trustees

### Officers

PRESIDENT	Cyril C. Wiggishoff, M.D., 25 E. Washington, Chicago 60602
PRESIDENT-ELECT	Robert P. Johnson, M.D., 3000 Bennington Ave., Springfield 62704
1st VICE-PRES.	Maynard I. Shapiro, M.D., 7531 Stony Island, Chicago 60649
2nd VICE-PRES.	Eugene P. Johnson, M.D., P.O. Box 68, Casey 62420
SEC.-TREAS.	Jere E. Freidheim, M.D., 3050 S. Wallace, Chicago 60616
CHAIRMAN, BOARD OF TRUSTEES	Warren D. Tuttle, M.D., 203 N. Vine, Harrisburg 62946

### House of Delegates

SPEAKER	Clifton L. Reeder, M.D., 516 Sheridan Road, Wilmette 60091
VICE-SPEAKER	Julian W. Buser, M.D., 6600 W. Main, Belleville 62223

### Trustees

1st District	1984	John J. Ring, M.D., 511 E. Hawley, Mundelein 60060
2nd District	1983	Allan L. Goslin, M.D., 712 N. Bloomington, Streator 61364
3rd District	1985	Richard Blankshain, M.D., 715 Lake St., Oak Park 60301
	1985	Alfred J. Clementi, M.D., 675 W. Central Rd., Arlington Heights 60005
	1983	Audley F. Connor, Jr., M.D., 7531 Stony Island, Chicago 60649
	1984	Morris T. Friedell, M.D., 7531 Stony Island, Chicago 60649
	1983	Robert C. Hamilton, M.D., 711 W. North Ave., Chicago 60610
	1984	Henrietta Herbolsheimer, M.D., 1700 E. 56th St., Chicago 60637
	1984	Lawrence L. Hirsch, M.D., 2434 Grace, Chicago 60618
	1983	Harold J. Lasky, M.D., 55 E. Washington, Chicago 60602
	1983	Richard N. Rovner, M.D., 645 N. Michigan, Ste. 543, Chicago 60611
	1983	Joseph C. Sherrick, M.D., 303 E. Superior, Rm. P-232, Chicago 60611
4th District	1985	George H. Burke, M.D., 2701-17th St., Rock Island 61201
5th District	1985	Robert L. Prentice, M.D., 2248 Warson Road, Springfield 62704
6th District	1984	Robert R. Hartman, M.D., 1040 College, Jacksonville 62650
7th District	1985	Alfred J. Kiessel, M.D., 1 Powers Lane Place, Decatur 62522
8th District	1985	Arthur R. Traugott, M.D., 602 W. University Avenue, Urbana 61801
9th District	1984	Warren D. Tuttle, M.D., 203 N. Vine, Harrisburg 62946
10th District	1984	Thomas P. Meirink, M.D., 8601 W. Main Street, Belleville 62223
11th District	1983	Kenneth A. Hurst, M.D., 52 Bunting Lane, Naperville 60565
12th District	1983	Joseph B. Perez, M.D., 5670 E. State, Rockford 61108

Trustee-at-Large	1983	Fred Z. White, M.D., 723 N. 2nd Street, Chillicothe 61523
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# HIGHLIGHTS OF THE 1982

## ANNUAL MEETING

### ISMS HOUSE OF DELEGATES

The 142nd annual meeting of the Illinois State Medical House of Delegates convened April 16-18, 1982, at the Palmer House Hotel, Chicago. More than 625 physicians, auxiliaries, medical students, medical residents and guests attended.

The first session of the House of Delegates was called to order by Clifton Reeder, M.D., speaker, at 9:30 a.m., Friday, April 16, 1982.

ISMS Secretary-Treasurer Eugene P. Johnson, M.D. conducted a brief memorial service for those members who had died in the past year. Special memorial resolutions were later adopted by the House, commemorating Francis W. Young, M.D., and Noel G. Shaw, M.D.

Dr. Young, a former member of the ISMS House of Delegates, also had been a member of the ISMS delegation to the AMA and a past president of the Chicago Medical Society. Dr. Shaw, also a past president of the Chicago Medical Society, had been a member of the ISMS House of Delegates and chairman of the ISMS Medical-Legal Council.

Later in the session, the House passed by acclamation a special resolution commemorating the contributions of ISMS Past President Edwin S. Hamilton, M.D. That resolution, introduced by H.P. Swartz, M.D., for the Kankakee County Medical Society, noted the late Dr. Hamilton's role as a founder of the World Medical Association; a member, secretary and chairman of the American Medical Association Board of Trustees and a trustee of the Interstate Postgraduate Medical Association of North America.

#### **Report of the Chairman, ISMS Board of Trustees**

Morris T. Friedell, M.D., chairman, ISMS Board of Trustees, updated activity since the 1981

Interim Meeting, indicating that all items referred by the House of Delegates had been addressed.

Dr. Friedell detailed recent programs implementing House directives and congratulated ISMS President Fred Z. White, M.D., for his successful term in office. Noting that much energy had been devoted to negotiations with the Illinois Department of Public Aid and related matters, Dr. Friedell thanked the members of the House and Board for their support, and referred the delegates to his written report for a more detailed analysis of the year's activity.

Dr. Friedell's written report touched upon extensive legislative involvement seeking to protect both the public and the profession. As noted verbally, Medicaid negotiations during implementation of the Medicaid Management Information Systems by the Illinois Department of Public Aid, had consumed considerable attention. Staff reorganization under the new executive administrator, Alexander R. Lerner, had brought new economy and efficiency. Communication, membership retention and promotion and CME programs had been addressed with new interest and concern.

Dr. Friedell's written report called upon the membership to bring a new energy to areas of growing concern: coalitions, AMA direct membership, voluntary health planning and private review.

A detailed analysis of Board of Trustees implementation of all referred resolutions completed the chairman's annual report.

#### **Illinois Governor James R. Thompson Addresses Delegates**

ISMS President Fred Z. White, M.D., introduced Illinois Governor James R. Thompson,



who told the House that he wanted, "to talk about the future of Medicaid." Gov. Thompson recounted the process of writing the Illinois state budget, describing decisions required to maintain a balanced ledger in an inflationary economy. "We are now entering the third straight year of static economic activity," he told the House, noting that he had been forced to cut nearly \$500,000,000 in order to balance the budget.

"Much of that money had to come from the Medicaid line items" he told the House, "particularly those for hospital reimbursement. I wrestled with those budget cuts, considering the impact on the economy as a whole in each case, and how each item affected the taxation/recession/taxation cycle."

The governor recounted experiences of "sister states," which had attempted to avoid cutting similar reimbursement areas, and the necessity of reviewing budget cuts within the total economic perspective. He reiterated a determination to maintain fiscal responsibility.

"The General Assembly will receive a balanced budget to review," he told the House of Delegates. "They may choose to raise revenues in a responsible way. But they must respect the bottom line of this budget: we will stand firm on paying our bills."

"We are going to respect the needs of our people," he continued. "Illinois is the fifth largest state in the Union. With strength and leadership in good times and in hard times, we will come out of this recession one of the strongest states in the nation."

The governor next turned to problems with Medicaid in Illinois. "You know what's wrong with the Medicaid system," he told the House. "It's a bad system. It doesn't see that the poor are treated, and it turns the normal doctor/patient relationship on its head."

Noting that regulations have forced people to use more expensive alternatives, he said, "this is not the right way to go about treating poor people. People who have no personal physician instead take their green cards to the nearest emergency room at much greater expense. I don't know who invented Medicaid or who designed it, but I think we should start over."

Gov. Thompson also cited President Reagan's similar willingness to "take a fresh look at things," and called for analysis of the Medicaid system.

"I would wager that if all providers . . . sat down to figure how to get needed medical care to the poor, and no more . . . at reasonable cost to the taxpayer, and no more . . . and reasonably reimburse the care givers, and no more . . . then we could start over and put together a reasonable

Medicaid program. We could show the federal authorities how it could be done."

"I want to try," he told the House. "If you will help me, I'll hold up my end."

Gov. Thompson went on to recount some difficult decisions in budget cutting of social welfare



Illinois Governor James R. Thompson

programs, and his efforts to maintain a balanced perspective on genuine needs and untapped community resources. Examples included residential sites for the blind, resources to aid programs for abused and neglected children and home health care for senior citizens.

"So we'll get to work on Medicaid," he told the House. "Maybe we can show the nation how a fair and rational and decent system works. I think we can do that."

### President's Night

Friday evening, April 16, more than 250 persons attended the dinner-dance honoring ISMS President Fred Z. White, M.D. Robert C. Hamilton, M.D., served as master of ceremonies for the program, which featured entertainment by the Franz Benteler Royal Strings.

### Public Affairs Breakfast

The Honorable Newton L. Gingrich (R-Georgia), United States Congressman from the Sixth District, gave the keynote presentation at the ISMS Public Affairs Breakfast on Saturday morning, April 17. Sponsored by the ISMS Public Affairs Committee and chaired by Herbert Sohn, M.D., the breakfast was attended by more than 275 persons. Congressman Gingrich, a strong proponent of fiscal responsibility, stressed the value of conservative budget mechanisms. He

also discussed the role of political action committees as vital components of the democratic process.

The Public Affairs breakfast also featured a brief presentation by Thomas C. Schrepfer, M.D., the Republican candidate for state representative from the 91st district. Dr. Schrepfer, a family physician from Havana, Illinois, is a clinical associate professor of medicine at the Peoria School of Medicine and a founding member of the Mason County Board of Health. He is secretary of the Fulton County Medical Society, a member of the ISMS/Illinois Agricultural Association Medical Student Loan Fund board and an active member of the local farm bureau. In addressing those at the breakfast, Dr. Schrepfer expressed appreciation for their support in the primary election, and urged that more physicians become involved in the political process.

#### **AMA-ERF Check Presented**

Marshall Falk, M.D., representing the Illinois Council of Medical School Deans, was introduced to the House of Delegates, and presented with a check for \$114,000, representing this year's contribution to Illinois medical schools from the American Medical Association Education and Research Foundation.

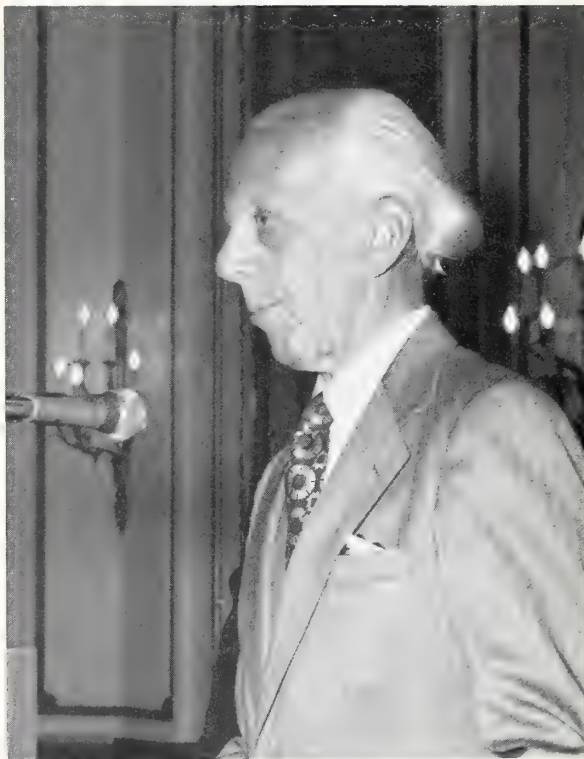


**Marshall Falk, M.D., accepts AMA-ERF check for the Illinois Council of Medical School Deans**

Dr. Falk expressed appreciation to Illinois physicians for their support of the program and its unrestricted grant funds.

#### **Fred A. Tworoger, M.D., Honored**

ISMS President Fred Z. White, M.D., presented a certificate of appreciation to Fred A. Tworoger, M.D., for his years of service. The accolade, adopted by affirmation of the House of Delegates, cited Dr. Tworoger's roles as a past president of the Chicago Medical Society, as well as secretary and chairman of the CMS Council. It noted his



**Fred Tworoger, M.D.**

role as ISMS delegate and alternate delegate to the American Medical Association, and a member and chairman of many ISMS councils and committees.

In accepting the award, Dr. Tworoger recalled the satisfaction derived from his years of service, and his regret to leave Illinois at retirement.

#### **James W. West, M.D., Receives Award**

ISMS President Fred Z. White M.D., next called James W. West, M.D., founder and former chairman of the ISMS Panel for the Impaired Physician, to receive a plaque in appreciation of his efforts. Dr. White read the plaque to the House, citing "dynamic work to coalesce ISMS activity in peer education of physician impair-



# Scenes from the ISMS Annual Meeting



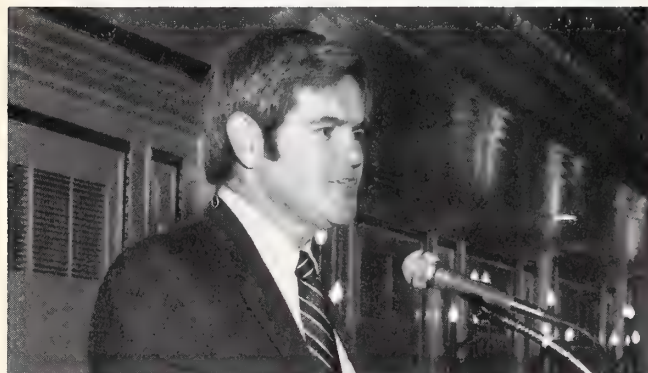
Dr. and Mrs. Cyril C. Wiggishoff immediately after his inauguration as ISMS president.



Thomas C. Schrepfer, M.D., Havana, candidate for state representative from the 91st district (L) with Robert P. Johnson, M.D., Springfield, ISMS President-Elect.



Fred Z. White, M.D. (L) displays past president's plaque and newly-inaugurated ISMS President Cyril C. Wiggishoff, M.D., prepares to present past president's scrapbook.



The Hon. Newton L. Gingrich, U.S. Congressman, Sixth District-Georgia, addresses ISMS Public Affairs Breakfast.



Frank J. Jirka, Jr., M.D., candidate for AMA President-Elect with AMA President Daniel Cloud, M.D.



Members of the ISMS Board of Trustees





**Dr. and Mrs. Fred Z. White**



**Dr. and Mrs. Cyril C. Wiggishoff**



**Warren D. Tuttle, M.D. and Mrs. Bette DiTullio**



**Mr. and Mrs. Alexander R. Lerner**

## **President's Night Honoring Fred Z. White, M.D.**



**Robert C. Hamilton, M.D.,  
Master of Ceremonies**



**Dr. and Mrs. Morris T. Friedell**



**Dr. and Mrs. Eugene P. Johnson**



ment and medical treatment of alcoholism . . . in recognition . . . of understanding of the healing arts and selfless devotion to those in need."

Dr. West, who has relocated to California, thanked the House for the award, saying, "The Panel for the Impaired Physician, and those who have benefitted by the efforts of the Panel—thank you and all the members of the Illinois State Medical Society, for your support."

#### **Illinois Society, American Association of Medical Assistants**

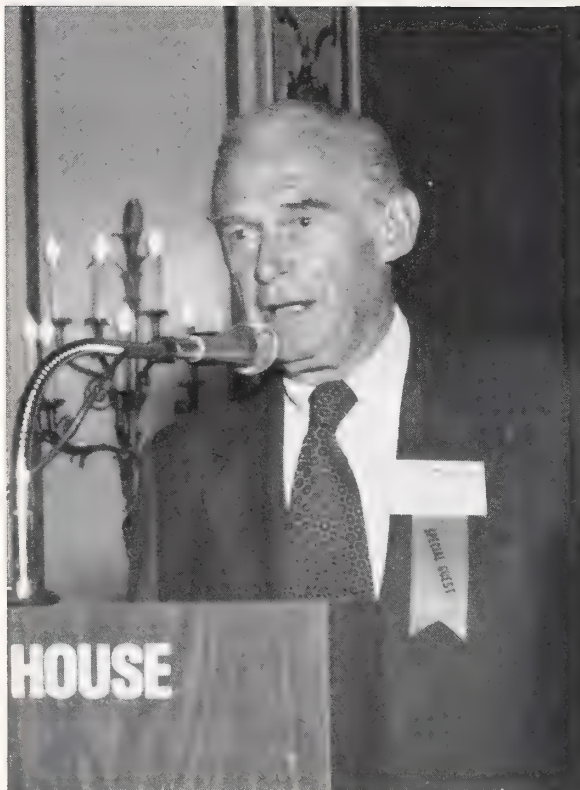
Mary Lou Ostrowski, CMA, was introduced to the House by Robert R. Hartman, M.D., in his role as a member of the national advisory committee to AAMA and ISMS liaison to the Illinois Society, AAMA. Ms. Ostrowski affirmed that the sole purpose of their group was to better medical practice in the community. Naming the benefits of membership for medical assistants in the areas of continuing education, publications and professional expertise, Ms. Ostrowski urged physicians to encourage their medical assistants to join the organization.

#### **ISMS Auxiliary**

ISMS Auxiliary President Mrs. Harold Keegan was introduced to the House by Clifton L. Reeder, M.D., speaker. Mrs. Keegan referred the House to the ISMSA written report, and provided highlights of the past year.



**Mrs. Harold Keegan, ISMS Auxiliary president**



**James W. West, M.D.**

The Auxiliary had sponsored Leadership Seminars for county officers, she noted, adding, "Leaders are not born, they're made. This is one way to show the members that you are returning their dues to them."

Mrs. Keegan recounted travel to other state auxiliaries and county societies, then turned to their major goal of establishing a closer working relationship with ISMS. Steps toward that end had included establishing staffing responsibilities from the ISMS headquarters office, which would provide a dual benefit of ISMS staff expertise for the Auxiliary and ISMS access to Auxiliary resources.

Membership had been another major area of Auxiliary efforts, Mrs. Keegan told the House. She urged physicians to encourage their spouses to join the ISMSA.

Closing with an account of successful efforts to raise funds for the American Medical Association Education and Research Foundation, Mrs. Keegan thanked the Society members for their continued support.

#### **Illinois AMA Delegation Heralds Jirka Candidacy**

Theodore Grevas, M.D., chairman, ISMS Delegation to the American Medical Association, in-

formed the House that Illinois had qualified for a 16th delegate when membership exceeded 15,000 on December 31, 1981. "Coupled with other Illinois physicians representing various specialties," he told the House, "we will be a potent force."

Dr. Grevas referred the delegates to his written report for detail of specific actions and resolutions at the national level, and turned to the campaign of Frank J. Jirka, Jr., M.D., for president-elect of the AMA. Delegates were asked to assist this effort by contacting AMA delegates from their respective specialties and familiarizing them with Dr. Jirka's qualifications. "Support for Frank's candidacy has come from many corners of the AMA," he concluded. "He would do us all proud as a national leader."

Dr. Grevas next introduced the members of the ISMS Delegation to the AMA, who were roundly applauded by the House for their efforts in representing ISMS at the national level.

Dr. Jirka, an honorary AMA delegate, was next asked to address the House. He expressed his appreciation for the continuing support of ISMS members for his candidacy, and echoed Dr. Grevas' statements that his election would also represent a victory for the Illinois physician members. "The last ten months have been highly intense," he told the House. "But I think that it's worth it. I think that with your help we can be elected."

### **Accreditation Surveyors Honored**

Morris T. Friedell, M.D., chairman, ISMS Board of Trustees, next presented certificates of appreciation to the physicians, osteopaths and professors who had served as CME accreditation site visit examiners in the past year. So honored were: Eugene Scherba, M.D.; Roger A. Wujek, M.D.; Alfred J. Clementi, M.D.; Joseph L. Daddino, M.D.; James M. Laidlaw, M.D.; Joseph B. Perez, M.D.; Anthony L. Barbato, M.D.; Lloyd Barr, Ph.D.; Bradford W. Claxton, M.Ed.; John G. Demakis, M.D.; Allan L. Goslin, M.D.; Thomas O. Henderson, Ph.D.; John M. Holland, M.D.; Ross N. Hutchison, M.D.; Harold L. Jensen, M.D.; Eugene P. Johnson, M.D.; Boyd E. McCracken, Sr., M.D.; Joseph C. Sherrick, M.D.; George Shropsher, M.D.; Harold A. Paul, M.D.; Chase P. Kimball, M.D.; Ben B. Blivaiss, Ph.D.; Fred Z. White, M.D., M.A.; E.C. Bone, M.D., M.A.; Kenneth A. Hurst, M.D.; Robert L. Prentice, M.D.; Linda K. Gunzburger, Ph.D.; Jacob R. Suker, M.D.; Marten M. Kernis, Ph.D.; Eugene T. Hoban, M.D.; Ward E. Perrin, D.O.; Donald F. Pochly, M.D., M.Ed.; and Michael H.M. Dykes, M.D., M.Ed.

### **Report of the Executive Administrator**

ISMS Executive Administrator Alexander R. Lerner then addressed the House. Recalling that this month marked the first anniversary of his appointment, he cited particular highlights of the year.

Staff reorganization had been completed, Mr. Lerner told the House. "As a result of reorganization, we have been able to achieve a more efficient and cost effective staff structure, increased upward mobility for staff with a clear description of each staff member's job responsibility and increased authority and responsibility at the divisional level."

Financial management had also been addressed, he reported, and, "by simply doing more with less, an audited budgetary surplus of \$57,000 was achieved for 1981." A more sophisticated accounting system was also being implemented, he reported. Zero-based budgeting and management by objective had been implemented for the 1982 budget, "to present a more sophisticated and accurate portrayal of the expected financial experience."

Finally, he said, staff had studied every ISMS activity which required funding in order to evaluate benefits vs. costs in each case. "Future programs designed to enable ISMS to achieve its goals and objectives also were examined carefully to develop accurate projections with regard to expected costs."

Another area of sustained activity was membership recruitment and insurance marketing. "Under the direction of the newly-created membership task force," Mr. Lerner told the House, "staff . . . are evaluating potential membership recruitment and insurance marketing approaches designed to increase physician participation in the Society, the Exchange and IMPAC."

"But, most importantly," he said, "it is through your leadership and continued commitment as members of the House that the Society will successfully meet the continuing challenges to the profession's ability to provide quality medical care. As ISMS staff, we look forward to your direction and wisdom."

"Let me conclude," Mr. Lerner said, "by offering my sincere thanks to the officers and trustees of the Society. The countless and often thankless hours which these dedicated physicians unselfishly put forth is the foundation of this association's strength. I and the entire staff are privileged to work with them."

### **President's Valedictory**

ISMS President Fred Z. White, M.D., gave his closing remarks to the House on Saturday morn-





Members of the ISMS Fifty Year Club

ing. He first recognized the county society leadership, ISMS Board of Trustees Chairman Morris T. Friedell, M.D. and ISMS Executive Administrator Alexander R. Lerner for their assistance over the past year. He also commended the ISMS staff working under Mr. Lerner for their outstanding efforts during the past year.

What came out of a year of transition, Dr. White told the House, is "a blueprint for the future." Dr. White then turned to summarizing the important events and results of his year as president.

"I hope that we will accept a dues increase," he told the House. "I put that first not because it will cost us more money, but because, with the reorganization we will be getting so much from that money."

"The second thing is my pride in noting that we have established a student loan fund within our Educational and Scientific Foundation. Also, we've achieved greater unity within our Society. This includes closer cooperation with the Auxiliary and ICCME's role."

Dr. White next turned to more philosophical changes of the past year, as well as trends in Illinois medicine. "I think that it's important to look at who we are," he said. "Solo practice is no longer the majority; the majority of our members are employed."

"On the national level, we lack a clear health policy," he said. "In the sixties, we decided that health care was a right for everyone. Eventually, funds shifted away from the direct physician-patient relationship, and focus on cost containment grew. Governor Thompson expressed the challenge before us yesterday: as long as the effort is not contained, the costs are not contained. Coalitions to address these things must include physicians, so we can be involved up-front."

Dr. White emphasized that the Society had developed goals a year ago, and that continued growth would be the product of continued review and re-affirmation of those goals, as appropriate.

"In so doing," he said, "I hope we will develop pro-active programs. We've been responsive and reactive—what we need is to be pro-active."

Dr. White closed his address with a quote from a popular ballad, calling upon members of the House to assert their abilities as builders and leaders. His presentation was followed by a standing ovation from the House audience.

#### **A Simulated Malpractice Trial**

The ISMS Medical Student Section sponsored an educational seminar, "Medical Malpractice: A Simulated Malpractice Trial," on Saturday morning. Judge James Murray and Attorney Thomas Maddux coordinated the program, designed to illustrate the medical/legal interface in the event of malpractice litigation.

On Saturday afternoon, the Medical Student Section held their annual business meeting. The following officers were elected for the 1982-1983 business year: Kurt Elward, chairman; Linda Tetzlaff, vice chairman/treasurer; Don Matsunaga, secretary; Malcolm Major, delegate; Patrick Merrill, alternate delegate; and Jim Glauber, MECO coordinator.

#### **ISMS Fifty Year Club Luncheon**

A total of 126 physicians were inducted as members of the ISMS Fifty Year Club at a Saturday afternoon luncheon. The Fifty Year Club now boasts some 850 members, who graduated from medical school at least 50 years ago.

Robert P. Johnson, ISMS first vice president, was chairman of the event, which included a talk entitled "My First Year in Practice," by newly-graduated OB-GYN physician Richard L. Dermody, M.D., from Breese, Illinois.

New members of the Fifty Year Club included Newton DuPuy, M.D., an ISMS past president; Maurice M. Hoeltgen, M.D., former speaker of the House of Delegates and chairman of the Illinois delegation to the AMA; Ralph Redmond, M.D., a past trustee of ISMS; and Charles Weigel, M.D., a Chicago Medical Society past president.

### Past President's Dinner

On Saturday evening, April 17, 12 ISMS past presidents gathered for the 19th annual past presidents' dinner at the Chicago Marriott Hotel. P. John Seward, M.D., 1979-1980 ISMS president, served as master of ceremonies, honoring immediate past president Herschel Browns, M.D.

### AMA President Addresses ISMS House

On Sunday morning, April 18, ISMS President Fred Z. White, M.D., introduced Daniel T. Cloud, M.D., president of the American Medical Association. Dr. Cloud, a pediatric surgeon from Arizona, is a former Illinoisian from Jacksonville who earned his medical degree at the University of Illinois. After completing residency at Children's Memorial Hospital in Chicago, he received training at the Peoria School of Medicine.

Dr. Cloud's comments began by addressing technological challenges of medicine in the eighties. "The artificial heart will be ready for clinical application in three to four years," he said. "Between 35,000 and 45,000 people would be eligible recipients—who will decide who should have it and how it will be afforded?"

"In the politics of medicine," he told the House of Delegates, "we will soon see the resolution of some of the questions such as who will bear the burden of determining access to medical care.

Cost, quality and access will be the biggest issues in medicine over the next several years."

Dr. Cloud cited inflation, demand, population increase and technological advances as the reasons for increased medical care costs. "Where does all that money go?" he asked. "There are six million people employed in health care in this country. That money goes back into the economy."

"And there's another of Newton's laws: every cost containment action has an equal and opposite economic reaction. It's important to keep that perspective."

"I believe that it's about time to reconvene the AMA Cost Commission," he said. "In 1978-79, we had the Voluntary Effort, and \$3 billion were saved in the first three years."

Still, Dr. Cloud cautioned that the initial "fat" had been cut with earlier efforts, and the remaining cost control programs would face greater challenges.

"Now we turn to a new development," he said, "coalitions." A coalition will not work unless two things are done, he cautioned. "It must be functional at the local level and certain essential elements—particularly physician participation—must be present. These elements are necessary, in health coalitions, to guarantee quality and accessibility."

"I urge you to support the coalition concept," Dr. Cloud told the House. "I urge you also to



ISMS Past Presidents (standing, L-R): David S. Fox, M.D., J. Ernest Breed, M.D., Jacob E. Reisch, M.D., J. M. Ingalls, M.D., Joseph H. Skom, M.D., George T. Wilkins, Jr., M.D., C. J. Jannings, M.D. and Willard C. Scrivner, M.D. Seated (L-R) are: Frank J. Jirka, Jr., M.D., P. John Seward, M.D., Herschel Browns, M.D. and Newton DuPuy, M.D.



demand physician participation. We must have a cogent, succinct, national policy on health care which addresses resources realistically."

Warning that experimentation is not an end in itself, Dr. Cloud turned to methods to introduce economy. "We need to introduce economy in hospital care," he said. "But I don't think that we'll do that while hospitals are so full. Presently, 42% of health care costs are in the hospitals—alternatives such as more pre-admission testing—should be explored."

"Another means to cut hospital utilization is consumer choice," Dr. Cloud said, citing disincentives in insurance plans as an example. "Over half of health care costs today could be prevented," he added, citing lifestyle diseases—such as those linked to cigarettes, as examples.

Dr. Cloud called upon the delegates to support the American health care system. In closing, he turned to the candidacy of Frank J. Jirka, Jr., M.D., for AMA president-elect. "I commend you for your decision to give a first rate candidate to the AMA," he said.

At the conclusion of his presentation, Dr. Cloud was elected a distinguished member of ISMS—the first physician so named.

### **Cyril C. Wiggishoff, M.D., Inducted as 130th ISMS President**

At the final session of the House on Sunday, Fred Z. White, M.D., administered the oath of office to Cyril C. Wiggishoff, M.D., as 1982-1983 ISMS president.

In his inaugural address, Dr. Wiggishoff first praised Dr. White's role in leading ISMS. "In the past year, he has traveled 23,000 miles. He has done more than anyone I know to bring together the people of our state. In every difficult decision," Dr. Wiggishoff told the House, "Fred White has shown himself to be a man of uncommon good sense and a man of fearless integrity."

"I realize the heavy responsibility that you have placed upon my shoulders," he told the House. "I know that your friendship will enable me to carry that burden without faltering."

Turning to the governor's address to the House on Friday, Dr. Wiggishoff called upon the delegates for a vigorous response. "We cannot let pass the governor's challenge," he told the House. "There is no doubt that the present method of bringing health care to the poor people of this state requires attention. I feel from your response to his speech that we have accepted the challenge."

"We have worked hard to develop alternatives to the present system of health care delivery,"



**Fred Z. White, M.D., (R) administers oath of office to Cyril C. Wiggishoff, M.D., the 130th ISMS president.**

Dr. Wiggishoff said. "The most important reason for our failures in this area is the unlimited ability of patients to seek medical advice at random. However, as we know, it is not uncommon for the medically indigent to seek advice in several physicians' offices and emergency rooms. Until recently, nothing could be done, due to federal regulation. But recently those regulations have become less restrictive."

"It is our intention to introduce at the next meeting of the House a resolution to restrict the medically indigent from making repeated visits of this kind. To echo the words of Winston Churchill, let us say to the governor, 'give us the tools and we'll finish the job!'"

### **Past President's Medallion**

Newly installed president Cyril C. Wiggishoff, M.D., presented the Past President's Medallion, a plaque and a scrapbook with news clippings from his year as president to Fred Z. White, M.D.

### **Post Convention Board of Trustees Meeting**

At the conclusion of the annual meeting, the ISMS Board of Trustees met to make several appointments and honor outgoing officers. Outgoing Chairman Morris T. Friedell, M.D., thanked those present for their cooperation during his terms as chairman. The Board nominated and elected Warren D. Tuttle, M.D., Harrisburg, to serve as chairman.

Plaques were presented to honor retiring trustees, as well as staff members making service milestones.

# SUMMARY OF MINUTES

## 1982 Annual Meeting House of Delegates

*The ISMS House of Delegates met at the Palmer House in Chicago, April 16-18, 1982, and took the following actions. The official minutes of the House are on file at the Illinois State Medical Society office.*

### SPECIAL ACTION

Substitute 13 (I-81)—Rescinded  
(*Special Report A-82*)—*Special Recommendation from Legal Counsel on Informed Consent*  
Introduced by Morris T. Friedell, M.D., for the Board of Trustees

Publication and implementation of this resolution was deferred upon advice of legal counsel, until the House was fully apprised of the ramifications of its action.

After suspension of House rules the resolution was rescinded and the Society directed to: (1) Endorse the Professional Standard Approach to informed consent, which states that a physician's duty of disclosure is determined by standards of the medical profession, which thus requires that disclosures made to patients conform to the general practices of the medical profession in the same or a similar community or locality, which disclosures are such which a reasonable medical practitioner would make under the same or similar circumstances; and (2) Oppose any proposed legislation to include a definition of informed consent in Illinois statutory law.

(See related action in Res. 11 (A-82) under Reference Committee A)

### OLD BUSINESS

29 (A-81)—Not Adopted  
(*BOT Report B*)—*Pre-Marital Testing for Syphilis*  
Introduced by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Defeated this resolution which called upon ISMS to actively promote the revocation of all mandatory pre-marital testing for syphilis.

### REFERENCE COMMITTEE ON CONSTITUTION & BYLAWS

3 (A-82)—Adopted  
*Amendments to Chapter II, Sections 3 & 4 of the Bylaws (removing "funds")*  
Introduced by Lawrence L. Hirsch, M.D., for the Board of Trustees

Amended Bylaws Chapter II as follows:  
Chapter II.

Dues and Assessments

Section 2. Reduction and Remission of Dues. Regular members may be given a fifty percent reduction in dues during the first year of practice, upon recom-



mentation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. Assessment. In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and approved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

#### 4 (A-82)—Adopted

*Amendments to Chapter VII, Section 12, of the Bylaws (naming "ISMS Benevolent Fund, Inc.")*

Introduced by Lawrence L. Hirsch, M.D., for the Board of Trustees

Amended Bylaws Chapter VII, Section 12 as follows:

##### Chapter VII.

##### The Board of Trustees

Section 12. The Benevolence Fund. Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund of a separate incorporated entity known as "the Illinois State Medical Benevolence Fund, Inc." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. Contributions and bequests to the Illinois State Medical Benevolence Fund, Inc. shall be deposited forthwith in said fund.

#### 5 (A-82)—Adopted

*Amendments to Chapter IX, Sections 2, 3, 5, 6, 7, & 8 of the Bylaws (removing "Liaison with AMSA," relocating description of Council on Af-*

*iliate Societies, and removing names of specific government agencies)*

Introduced by Lawrence L. Hirsch, M.D., for the Board of Trustees

Amended Bylaws Chapter IX, as follows:

##### Chapter IX. Committees

##### Section 2. Councils

C. The Council on Education and Manpower shall be concerned in the areas of:

1. Liaison with medical schools, curricula, etc.
2. Health manpower and training
3. Internships, residencies, etc.
4. Scientific assembly
5. Student loans
6. Continuing medical education

H. The Council on Affiliate Societies shall be concerned in the areas of:

1. Liaison between the affiliate society and ISMS
2. Scientific resource information and advice to ISMS
3. Consultation to other councils, e.g., postgraduate education, health care delivery, publicity, legislation
4. Advances of medical science in special fields
5. Recommendations to the Board of Trustees on legislative matters affecting any specialty society
6. Affiliate Societies
  - a. Qualifications. Affiliate societies shall be those recognized societies in Illinois.
    - (1) as may be approved by the Board of Trustees
    - (2) which desire representation on the Council on Affiliate Societies
  - b. Representation. Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

##### Section 5. Committees Reporting Directly to the Board of Trustees

C. Committee on Health Planning. The committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this im-

portant field. The committee shall maintain liaison with various organizations as determined by the Board of Trustees.

- E. Health Data Committee. The committee shall maintain ongoing awareness of (1) systems for the collection and dissemination of health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data, and (3) laws and government regulations pertaining to confidentiality. For committee purposes, health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of various organizations as determined by the Board of Trustees.

Section 6. House of Delegates Committees

- D. Committee on Constitution and Bylaws shall consider all proposed amendments to the Constitution, etc.

Section 7. Organization of House of Delegates Committees

- A. Immediately after the organization of the House of Delegates at each meeting, the speaker shall, etc.

Section 8. Board of Trustees Committees.

- G. The Board of Trustees may from time to time appoint such, etc.

6 (A-82)—Adopted

*Amendment to Chapter X, Section 4 of the Bylaws (to require members to comply with constitution and bylaws of constituent society)*

Introduced by Lawrence L. Hirsch, M.D., for the Board of Trustees

Amended Bylaws Chapter X, as follows:

Chapter X. County Societies

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the

jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws of ISMS and the constituent society.

7 (A-82)—Adopted

*Amendments to Chapter XI, Part 3 of the Bylaws (changing "Principles" of medical ethics to "Code")*

Introduced by Lawrence L. Hirsch, M.D., for the Board of Trustees

Amended Bylaws Chapter XI, as follows:

Chapter XI. Ethical Relations

Part 3. Offenses

- A. Disciplinary action may be taken against any member of a component society when:

2. He has been adjudged or otherwise recorded as guilty by his component society of:
  - b. a violation of the Constitution or Bylaws of his component society, or the Code of Medical Ethics promulgated by the Illinois State Medical Society.

17 (A-82)—Not Adopted

*Deadline for Submission of Resolutions*

Introduced by Raymond Hoffmann, M.D., for the Winnebago County Medical Society

Defeated this resolution which called upon the Society to set the deadline for submitting resolutions no less than 60 days prior to the opening of each session of the House of Delegates.

## REFERENCE COMMITTEE A

Substitute 10 (A-82)—Adopted

*Dues Increase*

Introduced by Eugene P. Johnson, M.D., Treasurer, for the Board of Trustees

Directed that: (1) A \$50 increase in annual dues to the Illinois State Medical Society be adopted in 1983, for a period of three years; and (2) No further increase of dues be made through 1985.



11 (A-82)—Adopted

*Procedure for Legal Counsel Review of House Actions*

Introduced by Clifton L. Reeder, M.D., Speaker

Directed that the following procedure be adopted for review of House actions prior to publication or implementation:

1. ISMS legal counsel will review all adopted resolutions for the purpose of assuring propriety, compliance with law, and protection of the profession.
2. That, based upon ISMS legal counsel opinion and advice that an adopted resolution may be illegal or inimical to the profession, upon consultation between legal counsel, the Speaker of the House, the Chairman of the Board of Trustees and the President, an action may be deferred from publication or implementation upon approval by the Board of Trustees.
3. If deferral of publication or implementation of an action by the House of Delegates is accomplished by the Board of Trustees, the Chairman of the Board of Trustees shall present a full and complete report to the next session of the House of Delegates, recommending rescission or amendment of the item which was deferred.

Also directed that this procedure be recommended to the AMA House of Delegates.

12 (A-82)—Adopted

*Modification of Dues Statement*

Introduced by Joseph Perez, M.D., for the Board of Trustees

Authorized the Board of Trustees to "add an amount equal to an AMPAC membership to a second voluntary contribution line of the 1983 dues billing."

16 (A-82)—Referred to Board

*Appointment of an Ad Hoc Committee of the House of Delegates to Adjust Downstate Trustee Districts' Boundaries*

Introduced by Jerry Ramunis, M.D., for the Knox County Medical Society

Referred to the Board of Trustees for study a proposal that ISMS develop "a specific plan to adjust downstate trustee districts' boundaries based on physician population distribution."

20 (A-82)—Adopted

*Redirection of One-Half the AMA-ERF Funds Given Annually to Medical Schools in Illinois for a Student Financial Assistance Program*

Introduced by Fred Z. White, M.D., for the Task Force on Financial Assistance to Medical Students

Directed that the Society: (1) Redirect one-half of the annual AMA-ERF funds (\$5.00), beginning with the 1983 dues billing, to be used as seed money for a financial assistance program for medical students; and (2) Establish this in the ISMS Educational and Scientific Foundation.

**Reports**

Filed the following reports for information:

President, President-Elect, 1st Vice President, Chairman of the Board of Trustees, Trustees, Executive Administrator, Secretary-Treasurer, AMA Delegation, ISMS Auxiliary, Illinois Society, American Association of Medical Assistants, Committee on Insurance, Illinois State Medical Insurance Services, Inc.

## REFERENCE COMMITTEE B

13 (A-82)—Referred to Board

*Monitoring UR Activities*

Introduced by Fred Z. White, M.D., President, for the Board of Trustees

Referred to Board of Trustees for study a proposal that "the Board of Trustees and ISMS staff, where not inappropriate, to monitor utilization review activities, to provide for the dissemination of appropriate information about these activities between ISMS and local physicians review entities, and to provide appropriate assistance upon request to local physician review entities."

15 (A-82)—Referred to Board

*Fee Discrimination*

Introduced by George Lagorio, M.D.

Referred to Board of Trustees for study a proposal that ISMS "take all appropriate action to remedy at the earliest possible moment discriminatory fee differentials in payment of Medicare claims."

18 (A-82)—Not Adopted

*Improving IDPA Physician Reimbursement Practices*

Introduced by Samuel J. Schimel, M.D.

Defeated this resolution which called upon the Society to make every effort to confront the IDPA, demanding that IDPA improve its reimbursement practices immediately so that physicians receive prompt payment for Medicaid services; and if this situation does not improve within the next four weeks, Public Aid patients will be charged the fee the physicians expect to receive from IDPA and the state reimburse the patient for the services.

19 (A-82)—Not Adopted

*IDPA Harrassment of Physicians*

Introduced by Samuel J. Schimel, M.D.

Defeated this resolution which called upon the Society to "notify the Governor of the State of Illinois that physicians object to being harrassed by the Illinois Department of Public Aid, which is refusing reimbursement to physicians because of minor errors on claims, and that physicians will not accept any more Public Aid patients until the situation is corrected."

Substitute 25 (A-82)—Adopted in Lieu of 25 (A-82) & 37 (A-82)

*Local Health Planning and The Coalition*

Introduced by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

*Alternative Proposals for Health Planning*

Introduced by Morris T. Friedell, M.D., for the Board of Trustees

Directed that the following be adopted as ISMS policy: (1) ISMS is opposed to a continuation of HSA activity at the State and Federal levels; (2) ISMS supports health planning on a local and voluntary basis with considerable input by physicians licensed to practice medicine in all its branches; (3) ISMS supports implementation of appropriate local health plans by the cooperative effort of the local community; and (4) ISMS supports the concept that the regulatory functions should be conducted independently of the planning process. Further directed that a similar resolution be presented to the AMA House of Delegates in June for action.

**Reports**

Filed the following reports for information:

Committee on Third Party Payment Processes, Committee on Health Planning, Committee on Health Planning Supplemental Report #1

## REFERENCE COMMITTEE C

21 (A-82)—Adopted as Amended

*Exposure of Residents to Alternative Practice Environments*

Introduced by Eugene B. Loftin, III, M.D., for the Wayne County Medical Society

Directed that ISMS, through its appropriate councils and committees, encourage primary care residency programs to establish educational activities in the rural and underserved areas of Illinois.

Substitute 22 (A-82)—Adopted

*Obligation of Physicians for Education Subsidies*

Introduced by Eugene B. Loftin, III, M.D., for the Wayne County Medical Society

Directed that: (1) ISMS continue to support the concept that graduates of state medical schools be encouraged to practice medicine in Illinois; and (2) ISMS councils, committees and other sources be used to develop positive incentives to fulfill this concept.

26 (A-82)—Adopted

*Cochlear Implants*

Introduced by William B. Frymark, M.D., for the DuPage County Medical Society

Directed ISMS to refer to the AMA Council on Scientific Affairs, the procedure of cochlear implants to determine if it can be recommended as an acceptable, and not experimental, procedure.

27 (A-82)—Adopted

*Physicians Recognition Award*

Introduced by Raymond A. Dieter, M.D., for the DuPage County Medical Society

Directed that ISMS encourage legislative and AMA-PRA changes so that the Physicians Recognition Award of the AMA will be acceptable to meet State of Illinois requirements for re-licensure.

30 (A-82)—Adopted

*Guaranteed Student Loan Program*

Introduced by Ronald M. Davis, for the ISMS/MSS

Directed that ISMS send letters to all Illinois U.S. Senators and Congressmen urging them to support the continuation of Guaranteed Student Loans to medical students.



## Reports

Filed the following reports for information:

Council on Education & Manpower, Resident Physician Section, Medical Student Section, Committee on Accreditation, Publications Committee, Educational & Scientific Foundation, Illinois Council on Continuing Medical Education, Task Force on Financial Aid for Medical Students, Student Loan Fund Board

## REFERENCE COMMITTEE D

### 9 (A-82)—Adopted as Amended

#### *Insurance Assignments*

Introduced by Robert C. Hamilton, M.D., Chairman, Cook County Delegation

Directed that: (1) It shall be the policy of the ISMS that when insurance benefits are assigned to a physician by a patient, care should be exercised by the insurance company, or its agent, in seeing that such wishes of a patient are followed; (2) If an error is made by the insurance company, or its agent, and payment is made to the patient, the insurance company is urged to admit its error and pay the physician as it was originally directed to do; (3) Under such circumstances recouping of the money from the patient is the responsibility of the insurance company, or its agent, that committed the error and not the responsibility of the physician; and (4) The intent of this resolution be referred to the AMA through the Illinois Delegation.

### 23(A-82)—Referred to Board

#### *Differential Reimbursement*

Introduced by Eugene B. Loftin, III, M.D., for the Wayne County Medical Society

Referred to the Board of Trustees for study a proposal that ISMS, through its appropriate councils and committees, develop a model reimbursement system that would be equitable.

### 32 (A-82)—Adopted as Amended

#### *Reduced Radiographic Examinations in Contested Workers Compensation Cases*

Introduced by Harold J. Lasky, M.D.

Directed that: (1) ISMS go on record as advocating a single shared radiologic examination to satisfy the medical requirements

at a given time in the course of a workers compensation injury; and (2) This position be communicated to the Illinois Industrial Commission, Illinois Bar Association and Workers Compensation insurance companies.

### Substitute 33 (A-82)—Adopted

#### *Catastrophic Health Insurance*

Introduced by Carlos B. Lara, M.D., for the Pike County Medical Society

Directed that: (1) The present position of the ISMS be reaffirmed, to "continue to support private, voluntary, catastrophic health insurance, including freedom of choice of physician;" and (2) Member physicians be made aware of the availability of the latest pamphlet by the Council on Medical Services of the AMA entitled, "Let's Talk about Health Insurance," and be encouraged to purchase booklets for distribution to their patients.

### Substitute 34 (A-82)—Adopted

#### *Outpatient Surgery*

Introduced by Charles A. Dekovessey, M.D., for the Richland County Medical Society

Directed that final medical decisions must remain in the hands of the attending physician. However, the ISMS adopts a policy of support for the concept of maximum utilization of outpatient surgical services consistent with the doctor's judgment and the facilities available.

## Reports

Filed the following reports for information:

Council on Medical Services, Council on Economics, Council on Mental Health and Addiction, and the Illinois Departments of Public Health, Children and Family Services, Corrections, and Rehabilitation Services

## REFERENCE COMMITTEE E

### 1 (A-82)—Referred to Board

#### *Liability Insurance Costs*

Introduced by Edwin Sinaiko, M.D.

Referred to the Board of Trustees for study a proposal that ISMS seek legislation authorizing payment by the State of a percentage of an M.D.'s liability insurance costs based on the percentage of his or her time devoted to IDPA patients.

**Substitute 2 (A-82)—Adopted**

*Tobacco Farm Subsidies*

Introduced by William B. Frymark, M.D., for the DuPage County Medical Society

Directed that the Society oppose the subsidization or price supports of tobacco farming.

**8 (A-82)—Adopted as Amended**

*Removal of Mandatory CME Requirements as Conditions for Medical License Renewal*

Introduced by Morris T. Friedell, M.D., for the Board of Trustees

Directed that the Society consider action to restore the voluntary system which has been a hallmark of competent physicians, as opposed to mandatory CME.

**24 (A-82)—Adopted as Amended**

*Block Grants to States*

Introduced by Morgan M. Meyer, M.D., for the DuPage County Medical Society

Directed the Board of Trustees to monitor carefully block grants to the states for certain categorical health programs so that ISMS will be able to recommend in a timely fashion the naming of physicians to State of Illinois agencies which will direct distribution of these funds.

**31 (A-82)—Adopted as Amended**

*State Preemption of Local Firearm Ordinances*

Introduced by Robert C. Hamilton, M.D., Chairman, Cook County Delegation

Directed that the Society: (1) Support the right of counties or municipalities to enact ordinances restricting the ownership, possession, purchase, sale, transport or transfer of firearms or firearm ammunition; (2) Oppose any state legislation in Illinois that would prohibit the enactment or enforcement of county or municipal ordinances restricting the ownership, purchase, sale, transport or transfer of firearms or firearm ammunition; and (3) Inform the members of the Illinois General Assembly and the Governor of Illinois of this position.

**Substitute 36 (A-82)—Adopted**

*Generic Drug Substitution*

Introduced by Dorothy Hubler, M.D., for the Clark County Medical Society

Directed that the Society: (1) Reaffirm its belief that only those drugs certified by the Technical Advisory Committee on Drug Product Selection of the Illinois Department of Public Health as being bio-equivalent be included in the drug substitution formulary;

and (2) Urge the Illinois Department of Public Health to monitor and enforce proper generic substitution by pharmacists.

**Reports**

Filed the following reports for information:

Governmental Affairs Council, Medical-Legal Council, Illinois Department of Registration and Education, Judicial Panel

## REFERENCE COMMITTEE F

**14 (A-82)—Adopted**

*Candidacy of Frank J. Jirka, Jr., M.D., for AMA President-Elect*

Introduced by Morris T. Friedell, M.D., for the Board of Trustees

Directed that ISMS: (1) Unanimously and enthusiastically endorse the candidacy of one of its most prominent members, Dr. Frank J. Jirka, Jr., for the office of President-Elect of the American Medical Association; and (2) Communicate its official endorsement of Dr. Jirka to the members of the AMA House of Delegates

**28 (A-82)—Adopted as Amended**

*Motorcycle Helmet Use*

Introduced by Ronald M. Davis, for the ISMS/MSS

Directed that: (1) All Illinois physicians encourage their patients who use motorcycles to wear a protective helmet; and (2) The *Illinois Medical Journal* publish a statement supporting the efficacy of such helmets in preventing death during collisions.

**Substitute 29 (A-82)—Adopted**

*Seatbelt Use*

Introduced by Ronald M. Davis, for the ISMS/MSS

Directed that the *Illinois Medical Journal* publish a statement containing statistics in support of seatbelt use benefits.

**Substitute 35 (A-82)—Adopted**

*Telephone Death Pronouncements*

Introduced by Ronald M. Davis, for the ISMS/MSS

Directed that the Society seek to remind physicians, nurses and other health care personnel to be aware of possible instances of abuse and neglect of the elderly, and encourage them to appropriately report suspected cases.



MEMORIAL RESOLUTIONS

The House also adopted memorial resolutions in memory of Drs. Edwin S. Hamilton, Kankakee; Noel G. Shaw, Chicago; and Francis W. Young, Chicago, and expressed its profound loss and condolences to their families.

AWARDS

The House also presented awards of appreciation to Drs. Fred A. Tworoger, Chicago, and James W. West, Evergreen Park, for their years of service to the Society.

ELECT OFFICERS,  
TRUSTEES,  
AMA DELEGATES

Dr. Cyril C. Wiggishoff, Chicago, was installed as ISMS president, succeeding Dr. Fred Z. White, Chillicothe.

Election of Officers

At the concluding session of the House, 1982-83 officers were elected unanimously. They are: Robert P. Johnson, M.D., Springfield, president-elect; Maynard I. Shapiro, M.D., Chicago, 1st vice president; Eugene P. Johnson, M.D., 2nd vice president; Jere E. Freidheim, M.D., secretary-treasurer; Clifton L. Reeder, M.D., Chicago, speaker of the house and Julian W. Buser, M.D., Belleville, vice speaker of the house.

Election of Trustees

Elected trustees were: Richard Blankshain, M.D. and Alfred Clementi, M.D., third district; George Burke, M.D., fourth district; Robert Prentice, M.D., fifth district; Alfred Kiessel, M.D., seventh district; and Arthur Traugott, M.D., eighth district.

Judicial Panel

Donald Aaronson, M.D., Chicago, was elected to serve a five year term on the ISMS Judicial Panel.

Illinois AMA Delegates

The House of Delegates elected AMA delegates and alternates to serve January 1, 1983

through December 31, 1984. Elected delegates were David S. Fox, M.D., Morris T. Friedell, M.D., Henrietta Herbolsheimer, M.D., Lawrence L. Hirsch, M.D., Joseph R. O'Donnell, M.D., John J. Ring, M.D., P. John Seward, M.D. and George T. Wilkins, M.D. Alternate delegates elected were Andrew J. Brislen, M.D., Audley F. Connor, Jr., M.D., Robert P. Johnson, M.D., Alfred J. Kiessel, M.D., Michael Nieder, Joseph B. Perez, M.D., Clifton L. Reeder, M.D. and Harry Springer, M.D.

Additional Delegate & Alternate

The House of Delegates elected Cyril C. Wiggishoff, M.D., Chicago, as the 16th delegate to take office immediately and serve until December 31, 1983. A. Beaumont Johnson, M.D., Elgin, was elected the alternate delegate to take office immediately and serve until December 31, 1983.

1983 Dues

The Speaker announced that the per capita dues for 1983 were set at \$253.

ATTENDANCE

The Credentials Committee recorded attendance of the 1982 House of Delegates as follows:

	First Session	Second Session	Third Session
Officers & Trustees	25	24	24
Speaker & Vice Speaker	2	2	2
District 1	7	9	4
District 2	2	3	2
District 3	83	76	79
District 4	9	11	8
District 5	7	7	6
District 6	5	6	4
District 7	5	5	2
District 8	6	6	7
District 9	6	5	5
District 10	5	6	5
District 11	14	14	13
District 12	8	9	10
Intern/Resident	1	0	0
Student	1	0	0
TOTAL	187	183	145

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# Viewbox

(Continued from page 389)

- DIAGNOSIS:** (1) Toxic megacolon  
(2) Amyloidosis  
(3) Analgesic-associated pseudo-obstruction

Patient one has a long history of ulcerative colitis and presented with toxic megacolon. Patient two had amyloidosis of the colon. Amyloidosis is more common in the light chain form of multiple myeloma. Patient three has a colonic pseudo-obstruction on the basis of high dose analgesic intake. The rectosigmoid is gas-filled in Figure 4, indicating absence of an obstructing lesion.

There are numerous causes of pseudo-obstruction (see Table 1). Many unusual and rare causes are included for the sake of completeness. A dilated colon due to pseudo-obstruction is a common problem. It may be difficult to exclude obstruction; barium enema or endoscopy may be required to resolve the issue. Awareness of the many causes of pseudo-obstruction will allow

earlier diagnosis. A special problem of pseudo-obstruction is toxic megacolon, which can be associated with high morbidity and mortality.

## Toxic Megacolon

In 1950, Marshak<sup>1</sup> introduced the term "toxic megacolon" to describe an acute complication of inflammatory bowel disease characterized by severe inflammation of the bowel wall leading to dilatation of part or all of the colon. The patient is often toxic. The clinical syndrome has a 10-20% mortality. Any inflammatory disease of the colon may give rise to this condition including pseudomembranous, bacterial, amebic, ischemic, and Crohn's colitis.<sup>2</sup> However, it is generally associated with ulcerative colitis and is seen as a complication of this disease in 1.6-8% of cases.<sup>3,4</sup> Opiates, anticholinergics, corticosteroids and barium enema are among the factors believed responsible for precipitating toxic megacolon in cases of inflammatory bowel disease.

Toxic megacolon may occur at any time during

TABLE 1  
CAUSES OF NON-OBSTRUCTIVE MEGACOLON<sup>2,6,7</sup>

(A)	<u>INFECTIOUS AND INFLAMMATORY</u>	1. Pneumonia	7. Toxic Megacolon
		2. Appendicitis	8. Antibiotic induced colitis
		3. Septicemia	9. Sprue
		4. Cholecystitis	10. Mesenteritis
		5. Pancreatitis	11. Amoebic colitis
		6. Inflammatory bowel disease	12. Chagas disease
	<u>NEUROGENIC</u>		13. Shigellosis
		1. Parkinsonism	4. Multiple Sclerosis
		2. Poliomyelitis	5. Familial autonomic dysfunction
		3. Hirschsprung's	6. Amyotrophic lateral sclerosis
(C)	<u>TRAUMATIC</u>		
		1. Spinal injury	
		2. Postoperative ileus	
		3. Ruptured aortic aneurysm	
		4. Post jejunoileal bypass	
		5. Hypoxia	
(D)	<u>ENDOCRINOPATHIES AND ELECTROLYTE IMBALANCES</u>		
		1. Hyper or hypoparathyroidism	5. Renal failure
		2. Myxedema	6. Pheochromocytoma
		3. Hypokalemia	7. Adrenal insufficiency
		4. Diabetes mellitus	8. Hypochloremia
(E)	<u>PSYCHOGENIC AND DRUG INDUCED</u>		
		1. Cathartic abuse	5. Psychotic induced megacolon
		2. Opiates and analgesics	6. Chemotherapeutic agents
		3. Alcoholism	7. Pseudo-Hirschsprung's
		4. Anticholinergics	
(F)	<u>DISEASES AFFECTING THE BOWEL WALL</u>		
		1. Ischemic colitis	5. CREST Syndrome
		2. Lymphosarcoma	6. Mixed connective tissue disorder
		3. Scleroderma	7. Myotonia dystrophica
		4. Amyloidosis	
(G)	<u>IDIOPATHIC INTESTINAL PSEUDO-OBSTRUCTION</u>		



the natural history of inflammatory bowel disease. It has been reported to affect infants under one month of age<sup>5</sup> as well as the very elderly. The individual whose disease is localized to only a portion of his colon is less likely to develop this syndrome than one with inflammation of his entire large bowel. Generally, the patient is acutely ill and may complain of lethargy, anxiety, or disorientation. On physical examination there may be a temperature of 101°-105°F, signs of impending shock, hypotension, tachycardia, abdominal distention and pain. The abdomen is usually silent and signs of peritonitis and perforation may be present. A potentially dangerous situation exists in the patient on ACTH or corticosteroid therapy in whom the signs of peritonitis or toxicity may be minimal. The individual with inflammatory bowel disease may actually feel improved with development of toxicity, due to the decreased number of stools per day associated with dilatation and aperistalsis of the colon. Occasionally, few physical signs of colonic dilatation are evident and it is in this instance that radiologic examination may first suggest the diagnosis.

On plain radiographs of the abdomen there is dilatation of part or all of the colon.<sup>6,7</sup> Intraluminal colonic air tends to rise to the highest possible position which, in the case of the supine patient, is the anteriorly placed transverse colon. Therefore, the transverse colon is generally seen to be the most distended segment of bowel on the supine abdominal film. The normal haustral pattern of the colon is disrupted and the haustra may be thickened or absent. "Thumbprinting" or broad based indentations of the colonic wall outlined by intraluminal gas may be seen. They represent thickening and infiltration of the wall of the large bowel. Many broad based nodular inflammatory pseudopolyps may be seen superimposed on this pattern of "thumbprinting" and extending into the colonic lumen. The mucosal pattern of the colon may appear irregular, with evidence of air filled crevices representing ulceration. Air fluid levels are characteristically few in number but long. Erect and right lateral decubitus films should be obtained to detect free abdominal air indicating perforation. Barium enema examination is contraindicated and has been implicated as a precipitating factor in toxic megacolon as well as a cause of colonic perforation in this condition. In general, barium examination of the colon is unnecessary, as the diagnosis may frequently be made on inspection of plain films. It has been recommended that radiologic examination of the patient suspected of developing toxic dilatation of the colon be done on a daily basis, as these

changes may develop in a very short time.

There are no pathognomonic histologic findings in this condition. In general, severe acute inflammatory changes are noted in all layers of the bowel wall with areas of necrosis and deep ulceration. There is evidence of muscle destruction and vasculitis with inflammation of small arterioles. Damage to mesenteric and submucosal nerve plexes is also seen. ◀

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7. Marshak, R.H., Lindner, A.E., Maklansky, D.: "RADIOLOGY OF THE COLON." W.B. Saunders Co., Philadelphia, 1980.

## The Cook County Graduate School of Medicine CONTINUING EDUCATION COURSES

### A.M.A. Accredited

#### August-September 1982

**Specialty Review in Internal Medicine, Certifying**  
July 25-31 or August 1-7, 1982

**Specialty Review in Emergency Medicine**  
August 2-6, 1982

**Specialty Review in Orthopedics**  
August 15-21, 1982

**Specialty Review in General Surgery, Part II**  
August 16-27, 1982

**Fiberoptic Colonoscopy**  
August 25-27, 1982

**Fiberoptic Esophagogastric Endoscopy**  
August 30-September 1, 1982

#### Subspecialty Review Series

**Hematology** August 30-September 3, 1982

**Infectious Disease** August 30-September 3, 1982

**Pulmonary Disease** August 30-September 3, 1982

**Nephrology** September 20-24, 1982

**Rheumatology** September 20-24, 1982

**Specialty Review in Dermatology**  
September 13-17, 1982

**Specialty Review in Pathology: Clinical**  
September 28-October 2, 1982

**Fiberoptic Colonoscopy**  
September 29-October 1, 1982

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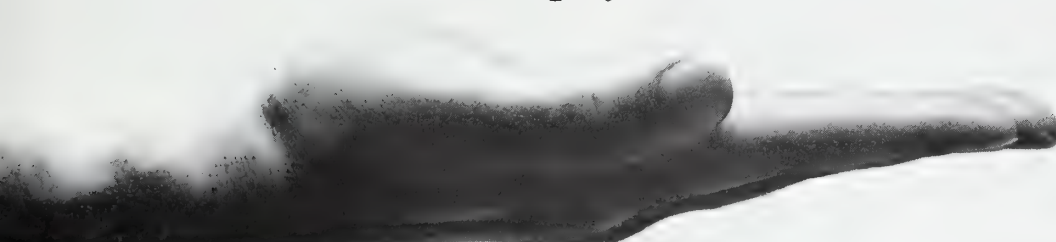
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I am a free citizen in a free nation.

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These things being true, I cannot--I will not--stand idly by when these hard-won freedoms are under attack.

I am also a physician, free thus far to treat my patients to the best of my ability.



Abridge that freedom and the health of my patients is adversely affected.

For I believe that the values upon which this country was founded are immutable and have not been eroded by the passage of years.

I believe that I, as a free citizen in a free land, am obligated to defend my beliefs in the ways permitted to me, and required of me, by our form of government.

Therefore, let no man seek to bar me from the political process; for it would be akin to denying my right to participate in the process that determines free government.

# Doctor's News

**LICENSE RENEWAL REMINDER**—The Illinois Department of Registration and Education has announced that all Illinois medical licenses will be subject to renewal by the Department before July 1, 1982. (Earlier announcements had erroneously set the renewal date at July 31.)

The Department mails license renewal forms to the "address of record," that is, the address listed by the physician at the time of 1980 license renewal. If the mailing address has changed in the interim, the physician is obliged to notify the Department.

Illinois law requires that continuing medical education (CME) credit be earned during the two year period ending March 31, 1982. At least 50 hours of Category 1 CME credit and an additional 50 hours of Category 2 credit must be earned by each physician during the two year period from April 1, 1980 through March 31, 1982. Of the 50 hours Category 1 credit, a minimum of 20 must be part of an approved, formal educational program as specified in the Medical Practice Act. The balance may fall into the realm of approved teaching or medical care audit activities.

Failure to renew on time results in a late fee penalty, and also could jeopardize liability insurance coverage. Further information may be obtained by contacting the Medical Licensure Section, Department of Registration and Education, 320 W. Washington St., Springfield, 62786; (217) 785-0800.

**IDPH REDUCTION**—IDPH announced a reduction in force, effective June 1, 1982, whereby the Regional Emergency Medical Services Coordinators will handle all ambulance licensure matters. The Regional Coordinators will continue to review EMT training program applications. The Department has announced that while it will not be possible for its regional staff to conduct any training programs, they will endeavor to monitor and review training programs on an "at random" basis. A list of the Regional headquarters can be obtained through the IDPH, 535 W. Jefferson St., Springfield, Illinois 62761.

**MATERNAL AND CHILD HEALTH TRAINING PROGRAM**—Physicians have been invited to attend a nine-month program, "Graduate Training in Maternal and Child Health" for Pediatricians at the Graduate School of Public Health, San Diego State University, August 1982 or August 1983. Applications or inquiries may be directed to Helen M. Wallace, M.D., M.P.H., Professor and Head, Division of Maternal and Child Health, San Diego State University, San Diego, CA 92182.

**HISTORY OF UROLOGY AND MEDICINE CATALOGUE**—The Joseph H. Kiefer Catalogue, a special collection publication, is for sale at the Library of Health Sciences, UI Medical Center.

Donated from 1972 through 1978, the Kiefer Collection gift was appraised at \$62,000 in 1979. Richard Meiers, Ph.D., History of Medicine, University of Chicago, compiled the Kiefer Catalogue in 1980. Dr. Kiefer's books include sections on surgery and general medicine, as well as urology care collections that date back to the twelfth century.

The Joseph H. Kiefer Catalogue of History of Urology and Medicine sells for \$10.00, paperbound, \$25.00 cloth bound and \$50.00 leatherstyle binding. To order contact the Library of Health Sciences, Library Administration, UI Medical Center, P.O. Box 7509, Chicago, Illinois 60680.



**PHYSICIANS IN THE NEWS**—**Robert M. Kark, M.D.**, Chicago, has been honored with mastership in the American College of Physicians. Dr. Kark joins an elite group of his medical colleagues. Of the 54,000 ACP members—doctors of internal medicine, related specialists and physicians-in-training—only about 150 are honored with the rank of ACP Master.

**Dinesh Desai, M.D.**, Chicago Heights, was recently elected a fellow of the American College of Physicians. Dr. Desai, a member of the staff at St. James Hospital, Chicago Heights, was honored for his outstanding scholarship and achievement in internal medicine.

The American Lung Association of Illinois has named **Dr. Lanie Eagleton, M.D.** Springfield, recipient of the 1982 Alma Fringer Award. Medical Director for the Lung Association Camp Superkids since 1978, Dr. Eagleton serves as chairman of the association Asthma Committee, and is assistant professor and chief, Pulmonary Disease, SIU School of Medicine.

**Earl E. Suckow, M.D.**, Mount Prospect, chief of pathology, Holy Family Hospital, received an award for serving three consecutive terms as chairman of the board of directors of the North Suburban Blood Center.

Newly elected officers to the Illinois Radiological Society for 1982-83 are: **Howard C. Neucks, M.D.**, Urbana, President; **Guy R. Matthew, M.D.**, Chicago, President-elect; and **Harold J. Lasky, M.D.**, Chicago, Secretary-Treasurer. Newly appointed councilors to the IRS for 1982-83 are: **Franklin S. Alcorn, M.D.**, Chicago, **George H. Burke, M.D.**, Rock Island; **Raymond L. Del Fava, M.D.**, Evanston; **Erwin M. Janzen, M.D.**, Springfield; and **Guy Matthew, M.D.**, Chicago. Alternate councilors are: **Donald W. Sherrick, M.D.**, Springfield, **Harold J. Lasky, M.D.**, and **James F. Chambliss, M.D.**, both of Chicago, **Howard C. Neucks, M.D.**, Urbana and **Stewart M. Spies, M.D.**, Highland Park. The Chicago Radiological Society division elected: **Lee F. Rogers, M.D.**, Chicago, President; **James J. Conway, M.D.**, Chicago, President-elect and Chairman; and **Franklin S. Alcorn, M.D.**, Chicago, Secretary-Treasurer. Central Illinois Radiological Society division elected: **Donald F. Anderson, M.D.**, Peoria, President; **Richard P. Taylor, M.D.**, Urbana, President-elect and **Alan J. Stutz, M.D.**, Springfield, Secretary-Treasurer.

**WMA-CME PROGRAM**—Physicians, medical educators and health care personnel are invited to attend the World Medical Association (WMA) CME Meeting in Honolulu, Hawaii, October 11-14, 1982.

Registration fee for this 19 hour Category 1 CME credit program is \$50. For further information contact the World Medical Association, North American Region, 536 N. State St., Chicago, Illinois 60610 or call Ms. Eva Stone (312) 751-6230.

**FPA ANNUAL MEETING**—The 28th annual meeting of the Flying Physicians Association will be held July 18-23 in Pheasant Run, St. Charles, Illinois.

The five-day program will consist of sessions on continuing medical education for the physician pilot, and a panel will discuss air safety and traffic control. Among the program lecturers will be Frank R. Hendrickson, M.D., director of the Neutron Therapy Facility, Fermi Laboratory, Batavia.

**INFORMATION FOR BIOGRAPHY NEEDED**—Do you remember Thomas Peter Garry, anatomist, who was associated with the Royal College of Surgeons, Dublin? Past students who have class notes and/or who attended his lectures, or anyone interested in assisting in a biography on the late anatomist, contact Dr. John Garry, 2971 W. 28th Ave., Vancouver, B.C., V6L 1X3.

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# Guide to Continuing Medical Education

## JULY

### Arrhythmias and Cardiac Ischemia

**For:** GP's, FP's, Internists. **Seminar,** July 30-Aug. 1, Boyne Mountain Resort, Michigan. **Sponsor:** International Medical Education Corp., 64 Inverness Drive East, Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours; ACEP, 13 hours. **Contact:** Doris Price. **Phone:** 800/525-8651 x 123.

### Cardiology

### Cardiology

#### ECG Interpretation and Arrhythmia Management

**For:** GP's, Internists. **Seminar,** July 30-Aug. 1, the Abbey, Lake Geneva, WI. **Sponsor:** International Medical Education Corp., 64 Inverness Drive East, Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours; ACEP, 13 hours. **Contact:** Doris Price. **Phone:** 800/525-8651 x 123.

### Dermatology

#### Practical Office Dermatology: A Course for Clinicians

**For:** Internists, Pediatricians, GP's, FP's. **Lecture,** July 12-16, Chicago. **Speaker:** Marshall Blankenship, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Reg. limit:** 85. **Credit:** Category 1, 37 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Emergency Medicine

#### 2nd Annual Common Emergency Care Problems: Managing the Unmanageable

**For:** MD's. **Conference,** July 23-24, Madison, WI. **Sponsor:** U of WI—Extension, 465B WARF Bldg., 610 Walnut St., Madison, WI. 53706. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 10 hours; AAFP Elective, 10 hours; AOA, 10 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

### Office Gynecology

**For:** Internists, GP's, FP's. **Lecture,** July 12-14, Chicago. **Speaker:** M. LeRoy Sprang, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$250. **Reg. limit:** 85. **Credit:** Category 1, 21 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Gynecology

### Environmental Medicine

**For:** Internists, GP's, FP's. **Lecture,** July 19-23, Chicago. **Speakers:** Stephen Greenberg, PhD; Emerson Day, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$325. **Reg. limit:** 85. **Credit:** Category 1, 30 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Medicine

### Medicine

#### Specialty Review in Pediatrics

**For:** Pediatricians. **Lecture,** July 19-24, Chicago. **Speaker:** Ira DuBrow, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 300. **Credit:** Category 1, 63 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Medicine

**Specialty Review Course in Internal Medicine/Certifying** **For:** Internists. **Lecture,** July 25 & Aug. 1, Chicago. **Speakers:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 600. **Credit:** Category 1, 72 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Summer Clinical Series

**For:** Urologists. **Course,** July 30-31, Palmer House, Chicago. **Sponsor:** American Urological Assn., P.O. Box 25147, Houston, TX 77265. **Reg. deadline:** 7/30. **Fee:** yes. **Reg. limit:** 200. **Credit:** Category 1. **Contact:** Alice Henderson. **Phone:** 713/790-6070.

## AUGUST

### Urology

### Electromyography

#### Electromyography and Clinical Neurophysiology

**For:** MD's. **Course,** August 3-6, Chicago. **Speaker:** Ian MacLean, MD. **Sponsor:** Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago 60611. **Fee:** \$175-250. **Reg. limit:** 36. **Credit:** Category 1, 26 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

### Emergency Medicine

#### Specialty Review in Emergency Medicine

**For:** Emergency Medicine Physicians. **Lecture,** August 2 (5½ days), Chicago. **Speaker:** James Mathews IV, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$425. **Reg. limit:** 175. **Credit:** Category 1, 45 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Family Medicine

#### Family Practice Seminar-at-Sea

**For:** MD's. **Symposium Cruise,** August 7-14, Bermuda. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 30 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Headache

#### Migraine Headaches

**For:** MD's. **Lecture,** August 20, 8:00 a.m., Chicago. **Speaker:** Robert Kunkel, MD. **Sponsor:** Grant Hospital, 550 W. Webster Ave., Chicago 60614. **Reg. deadline:** none. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** S. Smith. **Phone:** 312/883-2112.

### Internal Medicine

#### Specialty Review in Hematology

**For:** Hematologists, Oncologists, Internists. **Lecture,** August 30 (5 days), Chicago. **Speaker:** William Donnelly, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 175. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Internal Medicine

#### Specialty Review in Infectious Disease

**For:** Internists, Infectious Disease Specialists. **Lecture,** August 30 (5 days), Chicago. **Speaker:** Stuart Levin, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 175. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Internal Medicine

#### Specialty Review in Pulmonary Disease

**For:** Pulmonary Specialists, Internists. **Lecture,** August 30 (5 days), Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 175. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Legal Medicine

#### Medical-Legal Seminar-at-Sea

**For:** MD's. **Symposium Cruise,** August 14-21, Bermuda. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 30 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Medical Photography

#### Diving Medicine Seminar-at-Sea

**For:** MD's. **Symposium Cruise,** August 7-14, Bermuda. **Sponsor:** SIU School of Medicine, P.O. Box 3926, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 30 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Medicine

#### Specialty Review Course in Internal Medicine/Certifying

**For:** Internists, Medical Subspecialists. **Lecture,** August 1 (6½ days), Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 600. **Credit:** Category 1, 72 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Orthopedics

#### Specialty Review in Orthopedics

**For:** Orthopedic Surgeons. **Lecture,** August 15 (7 days), Chicago. **Speakers:** Peter Altner, MD; James Callahan, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 175. **Credit:** Category 1, 68 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Surgery

#### Fiberoptic Colonoscopy

**For:** Surgeons, Internists, Gastroenterologists. **Lecture,** August 25 (2½ days), Chicago. **Speaker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Surgery

#### Fiberoptic & Esophagogastroduodenal Endoscopy

**For:** Surgeons, Internists, Gastroenterologists. **Lecture,** August 30 (2½ days), Chicago. **Speaker:** C. Thomas Bombeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Surgery

#### Specialty Review in General Surgery, Part II

**For:** General & Specializing Surgeons. **Lecture,** August 16 (11 days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$600. **Reg. limit:** 300. **Credit:** Category 1, 99 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Sports Medicine

#### 5th Annual Sports Medicine Symposium

**For:** MD's, therapists. **Symposium,** August 14, Waukegan, WI. **Sponsor:** U of WI—Extension, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 6 hours; AAFP Elective, 6 hours; AOA, 6 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

# SEPTEMBER

## Clinical Hypnosis

### Workshops on Clinical Hypnosis

**For:** MD's, therapists. **Workshop, Sept. 23-25, Milwaukee, WI. Sponsor:** American Society of Clinical Hypnosis, Education and Research Foundation, 2250 E. Devon Ave., #336, Des Plaines 60018. **Fee:** \$125-375. **Reg. limit:** 150. **Credit:** Category 1, 22 hours; AAFP Elective, 22 hours; APA, 22 hours; AGD, 22 hours. **Contact:** Wilma Kafitz. **Phone:** 312/297-3317.

## Dermatology

### Specialty Review in Dermatology

**For:** Dermatologists. **Lecture, Sept. 13 (5 days), Rosemont. Speaker:** Marshall Blankenship, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Reg. limit:** 150. **Credit:** Category 1, 37 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Family Medicine

### Delivery of Health Care Services to Indochinese Refugees

**For:** MD's, allied health. **Symposium, Sept. 9, Madison, WI. Sponsor:** U of WI—Extension, 465B WARF Bldg, 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 6 hours; AAFP Elective, 6 hours; AOA, 6 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Infection Control

### Infection Control for Community Hospitals

**For:** MD's. **Symposium, Sept. 16, Madison, WI. Sponsor:** U of WI—Extension, 465B WARF Bldg, 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Credit:** TBA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Internal Medicine

### Specialty Review in Nephrology

**For:** Nephrologists, Internists. **Lecture, Sept. 20 (5 days), Chicago. Speaker:** Norman Simon, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 150. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Internal Medicine

### Specialty Review in Rheumatology

**For:** Rheumatologists, Internists. **Lecture, Sept. 20 (5 days), Chicago. Speaker:** William Arnold, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Nuclear Medicine

### Nuclear Cardiology Symposium

**For:** MD's. **Symposium, Sept. 22-25, Red Carpet Hotel, Milwaukee, WI. Sponsor:** U of WI—Extension, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** TBA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Ophthalmology

### Retinal Diseases and the Uses of Laser

**For:** Ophthalmologists. **Symposium/Workshop, Sept. 9-10, Chicago. Speaker:** Donald Gass, MD. **Sponsor:** Dept. of Ophthalmology, U of I College of Medicine, 912 S. Wood St., Chicago 60612. **Reg. deadline:** 8/26. **Fee:** \$300, symposium and workshop; \$200, symposium only. **Credit:** Category 1. **Contact:** Sue Korienek. **Phone:** 312/996-8025.

## Pathology

### Specialty Review in Pathology/Clinical

**For:** Pathologists. **Lecture, Sept. 28 (5 days), Chicago. Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 150. **Credit:** Category 1, 41 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Pediatric Surgery

### Care of the Seriously Ill Child

**For:** MD's. **Symposium, Sept. 29-30, Indianapolis, IN. Sponsor:** Division of CME, Indiana University School of Medicine, Indianapolis, IN 46223. **Fee:** \$85. **Reg. limit:** none. **Credit:** Category 1, 13 hours; AAFP Elective, 6 3/4 hours. **Contact:** Jay L. Grosfeld, MD. **Phone:** 317/264-4681.

## Spinal Cord Injury

### Management of the Spinal Cord Injured Patient

**For:** MD's. **Course, Sept. 13-16, Chicago. Speaker:** Terry Carle, MD. **Sponsor:** The Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago 60611. **Fee:** \$175-250. **Credit:** Category 1, 18 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

## Surgery

### Fiberoptic Colonoscopy

**For:** Surgeons, Internists, Gastroenterologists. **Lecture, Sept. 29 (2 1/2 days), Chicago. Speaker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

### Flap Symposium: Management of Large and Complicated Wounds

**For:** MD's. **Symposium, Sept. 11, St. Louis, MO. Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$100. **Reg. limit:** 150. **Credit:** Category 1, 7 1/2 hours; AAFP Prescribed, 7 1/2 hours; AOA, 7 1/2 hours. **Contact:** Loretta Giacoletto. **Phone:** 314/454-3873.

## CME PLANNING— THE NITTY-GRITTY

Even the best CME program can leave your colleagues dissatisfied if your planning has overlooked some critical detail. *CME Planning Checklists* can help assure that you achieve your CME program Goals; it offers four planning checklists to help remind you of every detail that can affect program quality. One of ICCME's most popular handbooks, it's available for \$8.00 postpaid (50% discount to ISMS members).

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## Tenth Illinois Congress on Continuing Medical Education

### "Determining What Physicians Need to Learn— Needs Identification in CME"

September 24-25, 1982  
Drake Oakbrook Hotel

This year's special anniversary program has been expanded to two full days and will include a variety of workshops on how to identify learning needs in your physician audience and how to select appropriate needs identification procedures.

Special keynote speaker will be Edmund D. Pellegrino, M.D., John Carroll University Professor of Medicine and Medical Humanities, Georgetown University Medical Center, Washington, D.C.

Full program details will be available after June 15; to receive a brochure and enrollment form, write or call . . .

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55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110



## TENTH ANNUAL CONGRESS/CME

# **Determining What Physicians Need to Learn—Needs Identification In Continuing Medical Education**

*September 24-25, 1982, at the Drake Oakbrook Hotel, West  
22nd St. at York Road, Oak Brook, Illinois.*

This year's Congress is the third in a four-year cycle covering the fundamentals of CME planning. The major emphasis in 1982 is on *how to identify physicians' learning needs*; the program will also include a variety of other topics that can satisfy CME concerns of physicians in Illinois and throughout the nation.

In response to demand, this year's special anniversary Congress has been extended to two full days—Friday afternoon and evening, all day Saturday—to offer you a wider choice of small group workshops and free time for informal discussion.

Highlighting this year's program will be Edmund D. Pellegrino, M.D., John Carroll University Professor of Medicine and Medical Humanities, Georgetown University Medical Center, Washington, D.C.

Among the small group workshops this year will be: Differentiating between Needs and Interests, Simulations in Needs Identification, Malpractice Data in Needs Identification, Expert Observation as Needs Identification, Interest Surveys and Audience Feedback, and Patient-Problem Inventory & Self Assessment Exams in Needs Identification.

Other workshops will include Introduction of Microcomputers, Introduction to Evaluation, and two special workshops for non-physician medical educators and administrative support staff.

For additional information, write or call the Illinois Council/CME, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603, (312) 236-6110.

# If you're concerned about tranquilizer "buzz," consider the low lipid solubility of Tranxene® clorazepate dipotassium

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Tranxene is available as 3.75, 7.5, 15 mg capsules, scored tablets; 11.25, 22.5 mg single-dose tablets. For brief summary please see an adjacent column.





## Prescribing information

**INDICATIONS** — For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

**CONTRAINDICATIONS** — Known hypersensitivity to the drug. Acute narrow angle glaucoma.

**WARNINGS** — Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

**Pregnancy and Lactation:** Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

**PRECAUTIONS** — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

**ADVERSE REACTIONS** — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

**INTERACTIONS** — Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

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**REFERENCES** — 1. Hollister LE: *Proceedings of Symposium, Anxiety: The Therapeutic Dilemma*, Monograph 97-0663:6, 1981. 2. Tranxene Drug Monograph 97-0185:9, 1981. 3. Greenblatt DJ et al: *Psychopharmacology* 66:289-290, 1979. 4. Biagi GL et al: *J Med Chem* 23:193-201, 1980.

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## Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style and order: Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal*. The *Journal*, however, will secure author permission before authorizing a reprint.



# LIFE AFTER 65... IN THE 1980's

## *More active than ever*

People are not only living longer these days, they're functioning better and leading more productive lives. A growing number of persons eligible for retirement are staying in the work force, some even venturing into second careers.

Those who do retire often choose active hobbies and investigate "late start" educational programs.

## *Medical advances have expanded the physically healthy years*

Significant medical advances, innovative methods of treatment, the development of new medications—these have played important roles in improving the quality of life for the older generation. In addition, there are now many social services available to help the elderly cope with their problems and enrich their lives.





***As with any age group, some cannot cope***

But advancing years do bring increased problems and, frequently, increased anxieties as well. Although many elderly people can cope with these anxieties—and can adapt to the inevitable changes of the later years—there are many who cannot. Their anxiety and psychic tension reach levels that can reduce their coping capacities, perhaps bringing productivity to a halt. Fortunately, the supportive care and empathy of the family physician go far to enhance the emotional well-being of these patients—and to ensure that life after 65 continues as active as before.

For some excessively anxious patients, pharmacological support may be indicated. Because of its special advantages and low-dose effectiveness, Valium (diazepam/Roche) 2 mg is an excellent choice for the elderly patient. Side effects more severe than drowsiness, fatigue and ataxia are rare and seldom serious. As with all CNS-acting agents, patients should be cautioned about drinking alcoholic beverages while on Valium therapy and engaging in potentially hazardous activities such as driving or operating machinery.

*When the emotional problem  
is excessive anxiety*

**VALIUM<sup>®</sup>**  
**diazepam/**  
**Roche**  
**2-mg scored tablets**



Please see summary of  
product information on following page.



# VALIUM<sup>®</sup> diazepam/ Roche

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**How Supplied:** For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100\* and 500.\* Prescription Paks of 50, available in trays of 10.\* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

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## Faculty Member Family Practice Program

The Black Hawk Area Medical Education Foundation is recruiting a Board Certified Family Physician to join its Family Practice Residency Program in Waterloo, Iowa. The program is community-based, affiliated with the University of Iowa College of Medicine, and part of the Iowa Network of Family Practice Residency Programs. The Waterloo metropolitan area has 125,000 people, four hospitals, and is well represented in the medical specialties.

Applicants should have an M.D. degree, be eligible for licensure in Iowa, and should have several years of practice experience. Major duties include teaching residents in all aspects of patient care, including obstetrics, and also providing patient care. Other duties include some program administration and assisting in research from time to time.

A salary in the range of \$60,000 per year with an additional 20% fringe benefit package is offered. Other fringe benefits relating to retirement, moving expenses, and continuing education are provided.

Please submit your resume to: Charles A. Waterbury, M.D., Program Director, Black Hawk Area Medical Education Foundation, 441 East San Marnan Drive, Waterloo, Iowa 50702, (319) 234-4419.

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# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**BENTON:** Family Physician wanted to join growing medical staff associated with a modern, 113-bed community hospital in southern Illinois. Guarantee and other benefits. Excellent recreational and university facilities nearby. CONTACT: Ann Acton, Franklin Hospital, Benton, 62812, (618) 439-3161, Ext. 367/368. (4)

**CARBONDALE:** Family or General Practice. Community Health Center in southern Illinois, 10 miles from SIU-Carbondale. Affiliation with Black Lung Clinic Programs possible. Established practice with multi-disciplinary staff. Position available immediately. Salary, fringe benefits are very competitive; malpractice insurance and vacation also provided. CONTACT: George M. O'Neill, Shawnee Health Service & Development Corporation, 103 S. Washington, #210, Carbondale 62901 (618-457-3351). (4)

**CENTRAL ILLINOIS:** Two community hospitals within twenty minutes of each other are currently seeking a urologist. Possible partnership with consulting urologist now servicing this area. More patients than one urologist can handle. Area is known for recreational activities. Contact: Search Committee, P.O. Box 430, Pana, 62557. (217-562-2131 x271) (4)

**CLIFTON:** Service Area, 8,500—Immediate opening for family practitioner in rural setting. First year: guarantee, office space/staffing provided. Seventy miles south of Chicago on interstate highway. Excellent school system. Obstetrics or general internal medicine background helpful. CONTACT: George Rasmussen, Central Community Hospital, Clifton 60927. AC 815-694-2392. (10)

**FAIRBURY:** Family practice physician—Excellent opportunity to join General Practice Physician planning retirement in two years. Cross coverage is available in this thriving rural practice. Fairbury Hospital, a 112-bed JCAH accredited hospital, offers income guarantees and other financial assistance. Contact: Kate H. Dickey, Director, Physician Recruitment, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739. (815-692-2346 x215) (4)

**GALESBURG:** Population 35,305. Seat of Knox County, pop. 61,300. An attractive college community 180 miles from Chicago. Near Peoria, Quad-Cities. Diversified industry and agribusiness. Full selection of educational, cultural and recreational activities. For information on practice opportunities, CONTACT: David D. Fleming, Vice-President, Galesburg Cottage Hospital, 695 N. Kellogg St., Galesburg 61401. 309/343-8131. (4)

**GIBSON CITY:** Family Practitioner—Excellent opportunity in East Central Illinois; modern, well equipped hospital with

attached private SNF; new professional office space and incentives available; rural community within 30 minutes of major university, tertiary care center, metropolitan area with major shopping, recreational and cultural activities. Contact: Daniel J. Marion, Executive Vice President, Gibson Community Hospital, Gibson City 60936 (217-784-4251). (9)

**KEWANEE:** 108 bed community hospital involved in an expansion program is interested in recruiting family practitioners to our service area of 35,000 population. Several practice opportunities exist in group or solo practices. The population centers in the service area range from 15,000 in population and less. Contact Harold L. Bischoff, Kewanee Public Hospital, 719 Elliott Street, Kewanee 61443 (309) 853-3361. (4)

**LINCOLN:** 20 miles from Southern Illinois University School of Medicine in Springfield and halfway between St. Louis and Chicago on I55. Need two family practice physicians for growing practice. Office facilities available with 10 man medical group. Contact Mary Richter, 311 Eighth, Lincoln 62656. (217/732-9681). (4)

**MARSHALL:** Population 4,000. County seat of Clark County. Rural community. Comparatively new medical center with available space for 4 doctors. Presently have 2 doctors. Facility fully equipped with lab, x-ray, therapy, emergency room, pharmacy. Located 17 miles from three major hospitals. Have excellent school system and recreational facilities. CONTACT: Donald B. Smitley, Admin., 410 N. 2nd St., P.O. Box 219, Marshall 62441, 217-826-2358. (4)

**METROPOLIS:** 8,000 population. Openings in Family Practice. 4 physicians at present. Southern Il. on Ohio river. Complete office facilities annexed to hospital. Financial assistance. Near two large lakes and recreational area. Just completing construction and renovation. 6-bed IC-CCU and 51 MS beds. CONTACT: Loren L. Erwin, POB 111, Metropolis 62960 (618-524-2176). (9)

**SULLIVAN:** Population 5,000. New medical center with complete office and ancillary services available. Near universities and colleges. All recreational facilities nearby. CONTACT: Sandra Elder, 2 W. Adams, Sullivan 61951 (217) 728-8316 or (217) 728-4186. (4)

**WATSEKA:** Population service area 35,000. Opening for orthopedic surgeon. 23 physicians on staff at present. 85 miles from Chicago in rural area, 160 bed hospital. Within one hour drive of major universities. Very liberal financial package available first year. Contact Paul F. Wenz, 200 Fairman Street, Watseka 60970. (815) 432-5201. (4)

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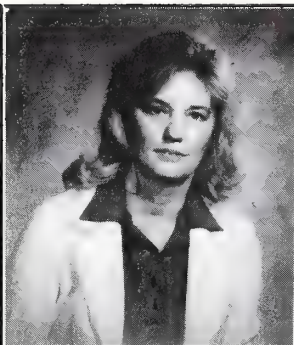
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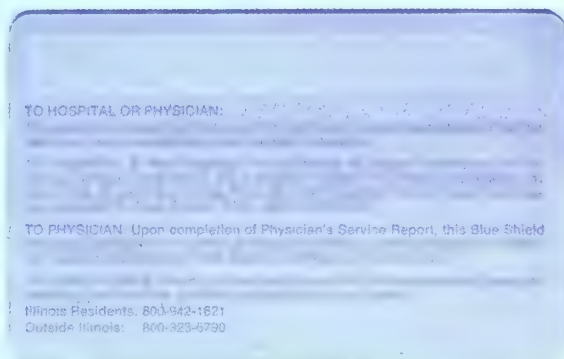
# REPORT

## FOR *Illinois Physicians*

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### NEW I.D. CARD ISSUED FOR JEWEL COMPANIES

Jewel Companies, Inc. distributed new plastic Blue Cross and Blue Shield identification cards to its employees during the month of March, 1982.



The front of the cards will display the Blue Cross and Blue Shield emblem and address in the upper left hand corner. The Jewel Companies, Inc. operating company insignia will be located in the upper right hand corner. The operating companies are Jewel, Eisner, Jewel-T, Park Corporation, Osco Drug, White Hen Pantry, Mass Feeding, Corporate Staff and Buttrey.

The identification number located in the center of the card consists of a five digit group number and a subscriber number consisting of a three digit number and the nine digits of the subscriber's social security account number.

The subscriber's name and the Illinois Plan BC 121 will be located in the lower left hand corner on the front of the card. Some of the cards will also have RX/FM COPAY in the lower left hand corner. This does not apply to Blue Cross and Blue Shield claims processing. All subscriber information will be embossed.

The back of the card contains the subscriber's signature and some provider instructions. See reverse side for list of Jewel Companies, group and section numbers.



Name of Jewel Company or Payroll Group	Group	Number
	Non-Medicare	Medicare

### Central Management Payroll

* Buttrey	80060/100-
Park Corporation	80063/100-
Jewel Food Stores	80063/110-
Corporate	80063/120-
Eisner Food Stores	80063/130-
Oscos Drug, Inc.	80063/150-
White Hen Egg Farm, Inc.	80063/160-
White Hen Pantry	80063/170-
Jewel T Discount Grocery	80063/180-
Mass Feeding	80063/200-

### Hospital-Medical Plan For Retired

Jewel Home Shopping	80073/100-	80073/101-
Jewel Food Stores	80073/110-	80073/111-
Corporate	80073/120-	80073/121-
Eisner Food Stores	80073/130-	80073/131-
Park Corporation	80073/140-	80073/141-
Oscos Drug, Inc.	80073/150-	80073/151-
White Hen Egg Farms, Inc.	80073/160-	80073/161-
White Hen Pantry	80073/170-	80073/171-
Jewel T Discount Grocery	80073/180-	80073/181-
Save-On-Drugs, Inc. (Oscos Personnel)	80073/190-	80073/191-
Buttrey	80073/200-	80073/201-

### Company Payrolls

Jewel Food Stores	80008/100-
Oscos Drug, Inc.	80055/110, 120, 130, 140, 150, 160, 170
Eisner Food Stores	80056/100-
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Corporate	80058/100-
White Hen Pantry	80059/100-
* Buttrey Food Stores	80060/100-
** Save-On-Drugs, Inc. (Oscos Personnel)	80061/100-
White Hen Egg Farms	80072/100-
Mass Feeding (Staff)	80074/100-
Jewel T Discount Grocery	80092/100-

\* Claims processed by Blue Cross of Montana

\*\*Plastic card not issued.

# Medicaid-Medicare-Champus Report

## More MMIS Claims Processing Clues

This article will highlight those areas which have created additional questions during the MMIS seminars sponsored by ISMS and conducted by ISMS staff. The ISMS staff will continue to provide periodic updates on items which have created problems for physicians who bill IDPA for services under MMIS.

**Sterilizations/Hysterectomies:** A sterilization procedure is a covered service *only* if the patient is over 21 years old and has signed an informed consent form at least 30 days but not more than 180 days prior to performance of the procedure. As a result of a recent Federal policy interpretation on sterilization and hysterectomies, the physician/surgeon must now sign the informed consent form *on the day that the sterilization procedure is performed*. An informed consent is not considered to be valid if it is obtained during labor, child birth, or while the individual is seeking to obtain an abortion. A hysterectomy is a covered service *only* when performed for reasons other than to accomplish sterilization. The patient and physician must sign an Acknowledgement of Receipt of Hysterectomy prior to the surgery. When filing a claim for these procedures, the physician must include these consent forms signed by all parties. Claims for these procedures are to be submitted in a Special Approval Envelope.

Hysterectomies that are performed as emergency procedures or in conjunction with another procedure and *not* for the purpose of rendering an individual sterile may be reimbursed without signatures on the consent form. However, if the consent form is not signed, the physician must supply documentation indicating the nature of the emergency surgery. If the physician providing service is an anesthesiologist, he *must* be sure that Box 23-E is completed with the proper role code: #7 - anesthesia. In addition, when billing for sterilization services the physician must complete Box 23-C on the form by checking "yes."

**Pricing Review:** ISMS has learned that many physician claims are being suspended for pricing review. Claims suspended for pricing review are individually evaluated to determine an IDPA-approved amount of reimbursement. A *pricing review* is not a review of physician charges for a particular procedure.

The pricing review mechanism was known as "hand pricing" under the pre-MMIS billing system. It should be noted that many claims for surgical procedures will warrant a pricing review. However, all claims for surgical procedures which are submitted with copies of the operative report, discharge summary or other supporting documentation, will be suspended for a pricing review. If a remittance advice sheet indicates that claims are suspended for a pricing review (code SS), those claims should not be rebilled. Once IDPA completes its review, those claims will be processed and the adjudicated claim will be reported on a future remittance advice sheet with a payment for the service.

**Adjustment Forms:** During the ISMS seminars on MMIS billing, several questions were asked about the proper use of the IDPA adjustment forms. The adjustment form is *only* to be used when requesting that IDPA reconsider a previously paid or reduced reimbursement on a claim for service. The IDPA adjustment form may not be used to request reconsideration of services that were rejected on a remittance advice sheet. IDPA will consider the use of the adjustment form in only four situations:

- if the physician receives a payment from an additional third party source that is greater than payment made by IDPA;
- if a service paid by IDPA was actually a duplicate payment or payment based on incorrect information entered in the service sections of the claim form, *e.g.*, incorrect procedure codes. However, if the claim was *rejected* for reporting incorrect procedure codes, the physician should not submit an adjustment form;



- to request reconsideration of the amount paid by IDPA. A physician who requests reconsideration should include *any* supporting documentation to describe the unusual circumstances or complexity of the procedure. Copies of the operative report and the discharge summary are acceptable documentation to accompany the adjustment form;
- if the total amount paid to the physician is in error, *e.g.*, if payment was issued by IDPA to the wrong physician.

**Inhalation Therapy:** During the ISMS/MMIS seminars, ISMS staff received several inquiries on inhalation therapy (respiratory ventilation). IDPA will reimburse physicians who provide this service to hospitalized patients with respiratory illness. The service is reimbursable to the physician only if personally performed by the physician. If the service is provided by a hospital staff physician, the procedure will be reimbursed only if the physician's contract with the hospital does not provide reimbursement for these services. In those circumstances where the hospital-based physician submits a claim to IDPA for respiratory ventilation, the physician must document that these services are not also reimbursed as part of his hospital employment contract.

When respiratory ventilation (inhalation) therapy is provided by the anesthesiologist who provides surgical anesthesia within two days of surgery, it is considered to be a part of the surgical anesthesia services and will not be reimbursed by IDPA as a separate service.

It is important to note that IDPA will only provide *one reimbursement* per patient, per day for this procedure, regardless of how often the treatment was given.

The physician's office personnel should use the appropriate CPT-4 procedure codes for hospital medical visits when billing for respiratory care.

**Claim Forms:** Some physician office personnel have experienced difficulty in obtaining supplies of the MMIS claim forms. IDPA plans to utilize a central distribution center to supply physicians with the necessary MMIS billing materials. The Department had considered alternative means to distribute forms. However, IDPA will be using the form usage information listed on the physician's original MMIS enrollment application to determine the amount of MMIS claim forms and envelopes the physician's office will require on a *quarterly* basis. Physicians who do *not* have a sufficient number of billing supplies should: (a) contact IDPA's Provider Participation Unit at P.O. Box 4034, Springfield, IL, 62768 or 800-252-8936; and (b) correct the anticipated amount of form usage shown on the physician's Provider Information Sheet and forward this information to the IDPA Provider Participation Unit.

**Medicare:** Recently EDS-F, the Medicare fiscal intermediary, began reviewing claims for hospital inpatient visits in excess of 24 days. EDS-F will allow visits in excess of 24 days if the HCFA 1490 claim form is accompanied by additional documentation that justifies the extended stay. However, EDS will allow visits in excess of this parameter without documentation for treatment of the following acute conditions: renal failure, myocardial infarction, cerebrovascular accident, and episodes of metastatic carcinoma. At a recent ISMS Board of Trustees meeting, several trustees requested a clarification of the type of supporting documentation that would justify hospital visits in excess of 24 days. EDS-F has indicated that physicians should show the reason for extended hospital stays in excess of 24 or 31 days either on the claim form or by appending information to the submitted bill. An example of the justifiable reasons would be a new diagnosis discovered after the patient was admitted, complications that resulted from a surgical procedure or medical treatment plan or a patient being admitted to the intensive care unit or critical care unit for CPR, etc. In order to fully document the complexities of the patient's condition, EDS-F requests that the date of the complicating factors be noted on the HCFA-1490.

Since April 5, EDS-F has been requesting additional data rather than denying payment on claims affected by the implementation of this policy. However, effective July 2, 1982 EDS-F will reject claims submitted for "routine" hospitalizations in excess of the 24 day parameter if the claim is submitted without the required documentation.

Physicians who have additional questions or require further clarification of the Illinois Department of Public Aid and/or the EDS-F Medicare Part B policies and procedures should feel free to contact their ISMS Field Representative at the ISMS offices, 312-782-1654. Physicians who are members of the Chicago Medical Society should contact the CMS offices (312-670-2550) with routine inquiries.







# Illinois Medical Journal

OFFICIAL JOURNAL OF THE  
ILLINOIS STATE MEDICAL SOCIETY

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**INDICATIONS:** *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions; otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

**CONTRAINDICATIONS:** Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-



mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

**PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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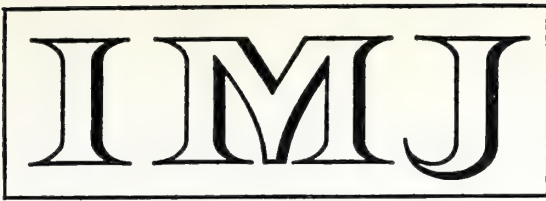
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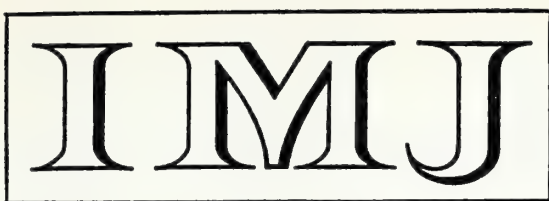
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The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional information magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge as a part of a continuing medical education program. Socio-economic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.



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# President's Page



## Wellness

The cost of medical services in the United States continues to escalate with increasing momentum. At present, health-related costs account for 10% of our gross national product. Many factors are involved in producing this phenomenon and they are attracting increasing attention, not only from those directly involved in providing medical services, but from independent observers as well. Some economists predict that society in general will prove obdurate in accepting any further increase in health care costs in relation to total general expenditures. They illustrate the obvious, that any greater expenditure on health care will leave individuals with fewer dollars to purchase a home, provide education for their children, pay for a new car or a long awaited vacation, as well as all the necessities of life.

The most effective, practicable economy is for individuals to have minimal encounters with the health care delivery system. Smoking, poor dietary habits, lack of exercise, and excessive alcohol consumption are important etiologic factors in diseases that have the greatest incidence in the United States, yet 60% of Americans are overweight and more than 35% smoke. In a recent national poll, over 80% of the respondents acknowledged that improving their lifestyle could do more to promote good health than a visit to a physician. Regrettably, other surveys show that the medical profession is failing to maximize its potential to influence changes in bad health habits. Less than one in ten of those who said they had been successful in losing weight attributed this to the advice of their doctor.

In brief, one has to conclude that many physicians are failing to provide leadership in the field of prevention. This responsibility includes all specialties. Every physician should take a few minutes to discuss general health care matters with each patient. Certainly, it will improve the doctor/patient relationship. Hopefully, it will help improve the patient's health. Possibly, it may reduce the incidence of professional liability suits. ◀

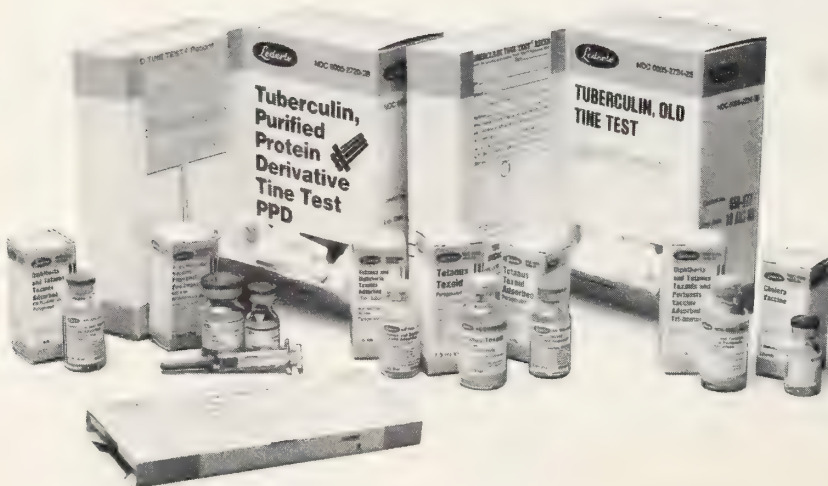
*C. C. Wiggishoff M.D.*

Cyril C. Wiggishoff, M.D., President





## The Lederle Defensive Line 75 years of Pediatric Protection



# President's Page

## Political Action Committees



It is common knowledge that running for election to public office is an expensive business—an expense which is often beyond the personal financial resources of the aspirant. If dedicated and talented people are to be attracted to serve at the various levels of government, be they local, state or national, then it is the responsibility of other citizens to see to it that these individuals are elected without incurring heavy financial liabilities. As a result, fund raising has become an integral part of politics in this country. Donations may be in cash or in services rendered and the rules governing their extent and nature are strictly monitored by the Federal Election Commission.

The ISMS and the AMA have each established political action committees with the acronyms IMPAC and AMPAC respectively. Under the Federal Election Commission rules governing such organizations, anyone may contribute any amount of money to either or both of the organizations. Each of these organizations has its own board of physician directors which is responsible for selecting the candidates to be supported and the amount of money or services to be allocated to such support. AMPAC concerns itself solely with national elections, while IMPAC concerns itself with elections in Illinois to all levels of government—congressional, gubernatorial and legislative. Occasionally, candidates to the local judiciary who are known to be supportive of physician concerns regarding professional liability issues have also been supported.

There are some who look askance at this type of activity as some sort of vote buying. Of course, this is not the case. It is perfectly legitimate and ethical for the medical profession, through the efforts of individual physicians, as well as through its organized societies, to support the election of individuals whom it knows to be receptive to its concerns and interests in the field of health care. Candidates for support are selected on these grounds alone and their party affiliation is never a consideration. Experience tells us that, once elected, they do not necessarily always vote on every issue in a manner satisfactory to the medical profession. That would be an unrealistic expectation. However, by careful selection, the profession can anticipate that those whom it has supported in their electoral activities will side with it on issues that it considers to be of fundamental importance in the promotion of the health of the citizens of this country and state.

In this, an election year, both IMPAC and AMPAC committees are busy selecting candidates for their support. All members of ISMS, and for that matter all physicians, should make whatever contribution they can afford to both organizations. There are some candidates at both the national and state level who cannot be included among those sympathetic to physicians' concerns. We should work toward their defeat at the polls in November and the election of those who understand the problems facing physicians and the patients whom they serve. ◀

*C. C. Wiggishoff M.D.*

Cyril C. Wiggishoff, M.D., President



One of nature's  
most predictable modalities...



*Alopex lagopus*

## THE ARCTIC FOX

The arctic fox is nature's turncoat. This small, curious animal, only about 2 feet long, lives on the barren tundra above the northern boundaries of tree growth. Because it neither migrates nor hibernates during the winter months, it is equipped with a very special kind of "reversible coat" that permits year-round habitation.

Like clockwork, the fox's gray-brown fur turns completely white as the winter solstice approaches, and then returns to its normal color during the spring thaw. The fox's coat also undergoes a smoky blue phase. This cyclical camouflage enables the fox to blend readily with the changing scenery of its environment, masking it from predators and prey.

The arctic fox: an animal whose coat is always in season. Few animals in nature have such a predictable pattern of adaptability.

In medicine, few drugs can match the predictable pattern of therapeutic action that you can expect with Librium. Well known for its safety, Librium provides prompt, effective relief of anxiety disorders and symptoms. At recommended doses it has virtually no effect on either the cardiovascular or the respiratory system, and rarely affects mental acuity. As with any drug in its class, patients should be cautioned about driving, operating hazardous machinery or drinking alcohol while on Librium therapy.

Librium. A natural selection for your clinically anxious patients.



For the treatment of anxiety

# Librium®<sup>IV</sup>

5 mg, 10 mg, 25 mg capsules

chlordiazepoxide HCl/Roche

## one of man's



**Librium®** (N)  
(chlordiazepoxide HCl/Roche)  
5 mg, 10 mg, 25 mg capsules

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Known hypersensitivity to drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety disorders and symptoms, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.*. *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl/Roche) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50. Libritabs® (chlordiazepoxide/Roche) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

## Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style and order: Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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*Illinois Medical Journal*

## On Being Relevant

*"The Illinois Medical Journal is published by the Illinois State Medical Society as an educational and professional information magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge as a part of a continuing medical education program. Socio-economic matters, effecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education."*

Each month, *IMJ* brings several clinical articles, regular columns in the specialties, and word of activity within the profession and the greater socio-economic context.

Predictably, late fall brings the annual reference issue, with information on how to find people and facts important to medical practice in Illinois. Spring means the annual meeting of the House of Delegates, with an issue devoted to a convention program and another to summarizing that event.

Major changes in the medico/legal arena have brought publication of guidelines or comments. These have related to the mental health code, when enacted, and the continuing medical education regulations, when revised.

But, more than anything else, the business that the *Journal* is about, is clinical medicine. Much is not predictable in clinical medicine. We're asking our readers, as clinicians and members, to help us to become less predictable.

The key, however, is your input. Instructions for authors are published each month, as shown on the table of contents.

The next time you want to comment on something that ISMS is or isn't doing—consider a letter to the editor. The next time you plan a clinical publication—consider sending the manuscript to *IMJ*. The next time a colleague mentions submitting an article—suggest the *Journal*.

It's up to you to keep us relevant.

J. William Roddick, Jr., M.D.  
Chairman, *IMJ* Editorial Board



## On the Cover . . .

The Illinois State Fair will be held in Springfield, August 5-15, and ISMS will again participate with an educational exhibit for the public.

For the 32nd year, the ISMS State Fair booth will bring public education in health concerns to the estimated 9,000 persons who will visit it.

Since 1978, the booth has been supported by a grant from the Division of Alcoholism, Illinois Department of Mental Health and Developmental Disabilities. It is designed and maintained under supervision of Jacob E. Reisch, M.D., Springfield, honorary ISMS past president and former secretary-treasurer.

This year's public education materials will give particular emphasis to emerging problems of teen alcohol abuse and the fetal alcohol syndrome. In addition, student members of the Sangamon County Medical Society, coordinated through the SIU School of Medicine, Springfield and ISMS Medical Student Section, will provide hypertension screening to the thousands of persons who pass through the booth.

ISMS members might encourage patients and families to plan a visit to the ISMS State Fair booth this year. The Fair is a tradition in itself. The booth is an ISMS tradition in public service.

## SOLVE YOUR PROTECTION PUZZLE

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# The Viewbox

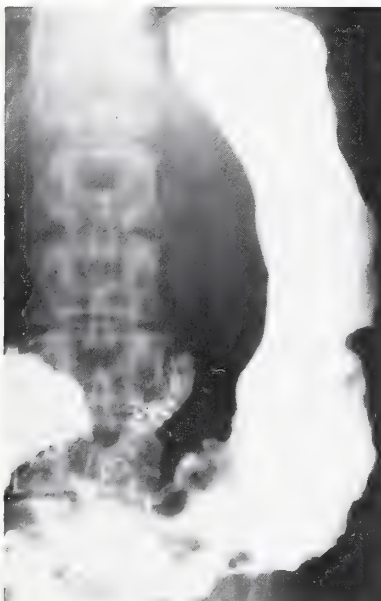
Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This month's Viewbox was contributed by Kenneth Baliga, M.D., Department of Radiology, Loyola University Medical Center, Maywood.*

*These three patients have minimal non-specific abdominal pain. They all have the same diagnosis.*



**Figure 1**  
Patient 1. Lateral view of barium filled stomach. This appearance was persistent.



**Figure 2**  
Patient 2. AP view of barium filled stomach.



**Figure 3**  
Patient 3. AP view of air contrast study of stomach. The round barium collection (arrow) was persistent and there were similar collections in the small intestine.

## Your diagnosis?

1. Non-Hodgkin lymphoma
2. Zollinger-Ellison syndrome
3. Gastric adenocarcinoma
4. Menetrier disease
5. Eosinophilic gastritis

*(Continued on page 51)*



# ***HYPERTENSION:***



# METHYLDOPA? RESERPINE? INDERAL? COUNTLESS

# THOUSANDS WOULD BE BETTER OFF WITH

Today, INDERAL—instead of methyldopa, instead of reserpine.

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INDERAL blocks beta-receptor sites *in the heart* to reduce heart rate and cardiac output—reducing cardiac work load—sparing an overburdened heart.

Hypertensive hearts can rest easy with INDERAL. For many—it is ideal, first-step therapy.

INDERAL—the sooner, the better for hypertension—a leading risk factor in coronary heart disease.<sup>1</sup>

# INDERAL<sup>®</sup>

## (PROPRANOLOL HCl) B.I.D.

### *The sooner, the better.*



\*Please see following page for Brief Summary of Prescribing Information.



# THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD

# INDERAL®

## (PROPRANOLOL HCl)

### B.I.D. FOR HYPERTENSION

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)  
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BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

#### CONTRAINDICATIONS

INDERAL is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

#### WARNINGS

**CARDIAC FAILURE** Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn. b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiological effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOLYCEMIA** Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**USE IN PREGNANCY** The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

#### PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

#### ADVERSE REACTIONS

**Cardiovascular** bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

**Central Nervous System** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

**Gastrointestinal** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

**Respiratory** bronchospasm.

**Hematologic** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Miscellaneous** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

#### ORAL

#### DOSAGE AND ADMINISTRATION

**HYPERTENSION** - Dosage must be individualized. The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

#### PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

#### INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

#### OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

**BRADYCARDIA** - ADMINISTER ATROPINE (0.25 to 1.0 mg) IF THERE IS NO RESPONSE TO VAGAL BLOCKADE. ADMINISTER ISOPROTERENOL CAUTIOUSLY.

**CARDIAC FAILURE** - DIGITALIZATION AND DIURETICS.

**HYPOTENSION** - VASOPRESSORS, e.g. LEVATERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

**BRONCHOSPASM** - ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

#### HOW SUPPLIED

INDERAL (propranolol hydrochloride)

#### TABLETS

No. 461 - Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462 - Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464 - Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468 - Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

#### INJECTABLE

No. 3265 - Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10.

Reference: 1. Freis, E.D. Hypertension (Suppl. II) 3:230 (Nov-Dec.) 1981

7997/482

**Ayerst** AYERST LABORATORIES  
New York, N.Y. 10017

## Obituaries

**\*Corbett, Robert James**, Chicago, died May 24, 1982 at the age of 69. Dr. Corbett was a 1946 graduate of the University of Health Sciences, Chicago Medical School, Chicago.

**\*\*Felsher, Isaac Myron**, Hallendale, Florida, died May 17, 1982 at the age of 85. Dr. Felsher was a 1928 graduate of Rush Medical College, Chicago.

**Hansen, Donald E.**, Evanston, died April 30, 1982 at the age of 68.

**\*Hoffman, Allen**, Wilmette, died May 9, 1982 at the age of 59. Dr. Hoffman was a 1947 graduate of the University of Health Sciences, Chicago Medical School, Chicago.

**\*Hurwitz, Chas Leland**, Skokie, died May 29, 1982 at the age of 72. Dr. Hurwitz was a 1938 graduate of the University of Health Sciences, Chicago Medical School, Chicago.

**\*Kaufman, Saul D.**, Chicago, died May 16, 1982 at the age of 68. Dr. Kaufman was a 1939 graduate of the University of Health Sciences, Chicago Medical School, Chicago.

**Khul, Paul E.**, Iowa City, died April 18, 1982 at the age of 63. Dr. Khul was a 1940 graduate of the University of Iowa College of Medicine, Iowa City.

**McGrady, James P.**, Gillespie, died April 13, 1982 at the age of 65.

**Montagnino, Joseph F.**, Chrisman, died April 18, 1982 at the age of 75. Dr. Montagnino was a graduate of St. John's College, New York.

**Moswin, Jack A.**, Gary, died April 23, 1982 at the age of 65.

**\*\*Shafer, Roger D.**, Christopher, died April 12, 1982 at the age of 82. Dr. Shafer was a 1931 graduate of the University of Health Sciences, Chicago Medical School, Chicago.

**Stadle, Wendell H.**, Battle Creek, Michigan, died April 30, 1982 at the age of 79. Dr. Stadle was a 1926 graduate of Northwestern University Medical School, Chicago.

**Thew, Thomas**, Chicago, died April 3, 1982 at the age of 45.

**Vikander, Thomas R.**, Farmington Hills, Michigan, died May 2, 1982 at the age of 30. Dr. Vikander was a 1977 graduate of the University of Illinois School of Medicine, Rockford.

**Weyerich, Leon F.**, St. Louis, died April 13, 1982 at the age of 73. Dr. Weyerich was a graduate of the St. Louis University School of Medicine.

*\*Indicates ISMS Member*

*\*\*Indicates member of the ISMS Fifty Year Club*

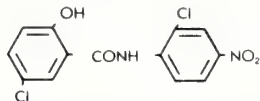


# Now available in the United States From Miles Pharmaceuticals

The scolex (below) has two elongated sucking grooves; the body (in background) may have as many as 4,000 proglottids



**DESCRIPTION:** NICLOCID (niclosamide) is an anthelmintic provided in chewable tablet form at a strength of 500 mg per tablet. Niclosamide is 2', 5-Dichloro-4'-nitrosalicylanilide. The empirical formula is  $C_{13}H_6Cl_2N_2O_4$  with the following structural formula.



**CLINICAL PHARMACOLOGY:** NICLOCID (niclosamide) inhibits oxidative phosphorylation in the mitochondria of cestodes. Both *in vitro* and *in vivo*, the scolex and proximal segments are killed on contact with the drug. The scolex of the tapeworm, loosened from the gut wall, may be digested in the intestine, and thus may not be identified in the feces even after extensive purging. The use of NICLOCID has not been associated with the development of anemia, leukopenia or thrombocytopenia nor have there been any effects on normal renal and hepatic functions.

**INDICATIONS AND USAGE:** NICLOCID (niclosamide) is indicated for the treatment of tapeworm infections by *Taenia saginata* (beef tapeworm), *Diphyllobothrium latum* (fish tapeworm) and *Hymenolepis nana* (dwarf tapeworm).

**CONTRAINDICATIONS:** NICLOCID™ Tablets are contraindicated in individuals who have shown hypersensitivity to any of its components.

**PRECAUTIONS:** NICLOCID affects the cestodes of the intestine only. It is without effect in cysticercosis.

**Drug Interactions:** No data are available regarding interaction of niclosamide with other drugs.

**Carcinogenesis, Mutagenesis, Impairment of fertility:**

**Carcinogenicity Potential:** Although carcinogenicity studies on niclosamide *per se* have not been done, long-term feeding studies on its ethanolamine salt in rats and mice did not show carcinogenicity. Mutagenicity tests have not been performed.

**Pregnancy: Pregnancy Category B:** Reproduction studies in rabbits and rats at doses of 25 times the human therapeutic dose and in mice at 12 times the human therapeutic dose, have revealed no evidence of impaired fertility or harm to the fetus due to niclosamide. There are, however, no adequate and well-controlled studies in pregnant women. Because animal studies are not always predictive of human response, the drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** No studies are available.

**Pediatric Use:** In children under 2 years of age, the safety of the drug has not been established.

**ADVERSE REACTIONS:** The incidence of side effects has been reported as follows: nausea/vomiting 4.1%, abdominal discomfort including loss of appetite 3.4%, diarrhea 1.6%, drowsiness, dizziness, and/or headache 1.4%, and skin rash including pruritus 0.3%. Other side effects listed in decreasing order of frequency were: oral irritation, fever, rectal bleeding, weakness, bad taste in mouth, sweating, palpitations, constipation, alopecia, edema of an arm, backache and irritability. There was also one instance of a transient rise in SGOT in an i.v. narcotic addict. Two cases of urticaria reported may be

related to the breakdown products of the tapeworm. All side effects were mild or moderate and transitory and did not necessitate discontinuation of the treatment.

**OVERDOSE:** Insufficient data are available. In the event of overdose a fast-acting laxative and enema should be given. Vomiting should not be induced.

## **DOSEAGE AND ADMINISTRATION:**

### **1. *Taenia saginata* and *Diphyllobothrium latum***

a. Adults: 4 tablets (2.0 g) chewed thoroughly in a single daily dose for 7 days.

b. Children weighing more than 34 kg (75 lbs): 3 tablets (1.5 g) chewed thoroughly in a single dose.

c. Children weighing between 11 and 34 kg (25 to 75 lbs): 2 tablets (1.0 g) chewed thoroughly in a single dose.

### **2. *Hymenolepis nana***

a. Adults: 4 tablets (2.0 g) chewed thoroughly in a single daily dose for 7 days.

b. Children weighing more than 34 kg (75 lbs): 3 tablets (1.5 g) chewed thoroughly on the first day, then 1 tablet (1.0 g) daily for next 6 days.

c. Children weighing between 11 and 34 kg (25 to 75 lbs): 3 tablets (1.0 g) to be chewed thoroughly on the first day, then one tablet (0.5 g) daily for next 6 days.

*T. saginata* and *D. latum* infections are usually due to single adult worm and require an intermediate host for their life cycle. With *Hymenolepis nana* multiple infections are the rule. No intermediate host is required in the human intestine where the complete life cycle occurs. Since the drug is more effective against cy-



# Pulse of the ISMS Auxiliary

**Are You Aware . . .**

## Pediatric Hypertension

BY DIANE HINDERLITER, ISMSA PRESIDENT

Hypertension (elevated blood pressure) was thought to be rare in children until approximately 10 years ago. Recent blood pressure screening has shown that elevated blood pressure in young persons is not uncommon. Studies have found that essential hypertension accounted for 45-100% of the observed hypertension in children between two and eighteen years of age.<sup>1</sup> In prepubescent children, essential hypertension is thought to account for 20-25% of all pediatric hypertension.<sup>2</sup>

Blood pressures were not routinely checked on otherwise healthy young children, (and for the most part still are not) because they often did not cooperate with the procedure and because abnormal results were not expected. Also, normal and abnormal criteria were not clearly designated for pediatric blood pressure readings.

Blood pressure normally increases from infancy through adolescence. It is not known exactly what level of blood pressure should be considered abnormal for any specific age, however a child whose diastolic BP is 90 or above could be considered hypertensive. Hypertension could also be defined as systolic and diastolic pressures that are sustained above the 95th percentile. The percentile approach is preferred by some experts because blood pressure does rise slowly with age. The percentile approach is supported by current data from previous and ongoing longitudinal studies which suggest that while blood pressures rise with age they also tend to remain in the same percentile

rank or track for the child's age and sex.<sup>3</sup> "Tracking," this phenomenon of "following" the blood pressure, is important. Children with pressures at the uppermost levels have been "tracked" and the pressures of most of them remained at the upper levels. Some hypertension specialists have suggested that the 75th percentile be utilized to identify children who require closer follow-up for their normal blood pressure.<sup>4</sup>

State and local blood pressure programs (often in conjunction with the American Heart Association) are developing guidelines for blood pressure screening in children which include measurement, public education standards and referral criteria.

Trained auxiliary volunteers have many opportunities to participate in blood pressure control. These include public education, screening and programming. These opportunities for auxiliaries are challenging and rewarding because the benefit from identifying one hypertensive child or adult is tremendous. ◀

### References

1. Loggie, J.: "ESSENTIAL HYPERTENSION IN ADOLESCENTS," Postgraduate Medicine, 56, 1974, p. 133-140.
2. Lieberman, E.: CHILDREN HAVE HYPERTENSION TOO, A Handbook for Pediatric Hypertension, American Heart Association, Greater Los Angeles Affiliate, 1979, p. 1-2.
3. Stamler, J., *et al.*: BLOOD PRESSURE IN CHILDREN, USA, Ciba-Geigy Corporation, 1980, p. 8-10.
4. Stamler, J., *et al.*: BLOOD PRESSURE IN CHILDREN, U.S.A., Ciba-Geigy Corp., 1980, pp. 5, 26.



**BECAUSE  
A THIAZIDE ALONE  
CAN ONLY DO  
SO MUCH...**

**AND YET  
CAN DO  
TOO MUCH.**



# INCREASE CONTROL WITHOUT INCREASING POTASSIUM PROBLEMS.

## **A dependable means to long-term blood pressure control.**

Many times, a diuretic alone can't keep hypertension in check. *INDERIDE*, however, can pick up where thiazide therapy leaves off.

The combination of propranolol HCl, the world's most trusted beta blocker, and hydrochlorothiazide, the standard among diuretics, enables *INDERIDE* to exert an additive antihypertensive effect.<sup>1,2</sup> In fact, a propranolol/hydrochlorothiazide regimen maintained blood pressure below 90 mm Hg in 81.8% to 86.4% of patients followed for 6 to 18 months of therapy.<sup>1</sup>

## **Low thiazide dosage means reduced risk of hypokalemia.**

When thiazides are prescribed in doses greater than 50 mg/day, the potential for hypokalemia increases substantially. What's more, the greater the fall in serum K<sup>+</sup>, the greater the risk of hypokalemia-induced PVCs.<sup>3,4</sup>

With *INDERIDE*, the additive hypotensive effect of propranolol HCl allows the effective dose of hydrochlorothiazide to be kept low (25 mg b.i.d.). And by lowering the daily dose of diuretic, *INDERIDE* also lowers the potential for diuretic-induced side effects. Potassium problems are less likely to occur—yet blood pressure can be controlled consistently.



# **INDERIDE<sup>®</sup>**

Each tablet contains *INDERAL*<sup>®</sup>  
(propranolol HCl) 40 mg or 80 mg,  
and hydrochlorothiazide 25 mg

**B.I.D. 40/25  
80/25**

## **When you know you need more than a thiazide.**

Please see Brief Summary of Prescribing Information on following page.



BRIEF SUMMARY  
(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

## INDERIDE®

BRAND OF  
propranolol hydrochloride  
(INDERAL®)  
and hydrochlorothiazide

No. 474—Each IINDERIDE®-40/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	40 mg
Hydrochlorothiazide	25 mg
No. 476—Each IINDERIDE®-80/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	80 mg
Hydrochlorothiazide	25 mg

**WARNING:** This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

**DESCRIPTION:** IINDERIDE combines two antihypertensive agents: IINDERAL (propranolol hydrochloride), a beta-adrenergic blocking agent, and hydrochlorothiazide, a thiazide diuretic-antihypertensive.

**INDICATION:** IINDERIDE is indicated in the management of hypertension. (See boxed warning.)

**CONTRAINDICATIONS:** **Propranolol hydrochloride (INDERAL®):** Propranolol hydrochloride is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors); and during the two week withdrawal period from such drugs

**Hydrochlorothiazide:** Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs

**WARNINGS:** **Propranolol hydrochloride (INDERAL®):** CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (*i.e.*, that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, *e.g.*, isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in re-starting and maintaining the heart beat has also been reported

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (*e.g.*, CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA:** Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

**USE IN PREGNANCY:** **Propranolol hydrochloride (INDERAL®):** The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

**Hydrochlorothiazide:** Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**Nursing Mothers:** Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing

**PRECAUTIONS:** **Propranolol hydrochloride (INDERAL®):** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

**Hydrochlorothiazide:** Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (*e.g.*, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

**ADVERSE REACTIONS:** **Propranolol hydrochloride (INDERAL®):** Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

**Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

**Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

**Respiratory:** bronchospasm

**Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (pralolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**Hydrochlorothiazide:** **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis

**Central Nervous System:** dizziness, vertigo, paresthesias, headache, xanthopsia

**Hematologic:** leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

**Cardiovascular:** orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics)

**Hypersensitivity:** purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions

**Other:** hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

**DOSAGE AND ADMINISTRATION:** The dosage must be determined by individual titration (see boxed warning).

Hydrochlorothiazide is usually given at a dose of 50 to 100 mg per day. The initial dose of propranolol is 40 mg twice daily and it may be increased gradually until optimum blood pressure control is achieved. The usual effective dose is 160 to 480 mg per day.

One to two IINDERIDE tablets twice daily can be used to administer up to 320 mg of propranolol and 100 mg of hydrochlorothiazide. For doses of propranolol greater than 320 mg, the combination products are not appropriate because their use would lead to an excessive dose of the thiazide component.

When necessary, another antihypertensive agent may be added gradually beginning with 50 percent of the usual recommended starting dose to avoid an excessive fall in blood pressure

**OVERDOSEAGE OR EXAGGERATED RESPONSE:** The propranolol hydrochloride (INDERAL) component may cause bradycardia, cardiac failure, hypotension, or bronchospasm.

The hydrochlorothiazide component can be expected to cause diuresis. Lethargy of varying degree may appear and may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function, and in the absence of significant serum electrolyte changes or dehydration. The mechanism of central nervous system depression with thiazide overdosage is unknown. Gastrointestinal irritation and hypermotility can occur; temporary elevation of BUN has been reported, and serum electrolyte changes could occur, especially in patients with impairment of renal function

**TREATMENT:** The following measures should be employed. GENERAL—If ingestion is, or may have been, recent, evacuate gastric contents taking care to prevent pulmonary aspiration. BRADYCARDIA—Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. CARDIAC FAILURE—Digitalization and diuretics. HYPOTENSION—Vasopressors, *e.g.*, levaterenol or epinephrine. BRONCHOSPASM—Administer isoproterenol and aminophylline. STUPOR OR COMA—Administer supportive therapy as clinically warranted. GASTROINTESTINAL EFFECTS—Though usually of short duration, these may require symptomatic treatment. ABNORMALITIES IN BUN AND/OR SERUM ELECTROLYTES—Monitor serum electrolyte levels and renal function; institute supportive measures as required individually to maintain hydration, electrolyte balance, respiration, and cardiovascular-renal function.

**HOW SUPPLIED:** No. 474—Each IINDERIDE®-40/25 tablet contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 476—Each IINDERIDE®-80/25 tablet contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100

**References:** 1. Veterans Administration Cooperative Study Group on Antihypertensive Agents: J. A. M. A. 237:2303 (May 23) 1977. 2. Bravo, E. L., Tarazi, R. C., and Dustan, H. P.: N. Engl. J. Med. 292:66 (Jan. 9) 1975. 3. Hollifield, J. W., and Slaton, P. E.: Acta Med. Scand. [Suppl.] 164:67, 1981. 4. Holland, O. B., Nixon, J. V., and Kuhnert, L.: Am. J. Med. 70:762 (Apr.) 1981.

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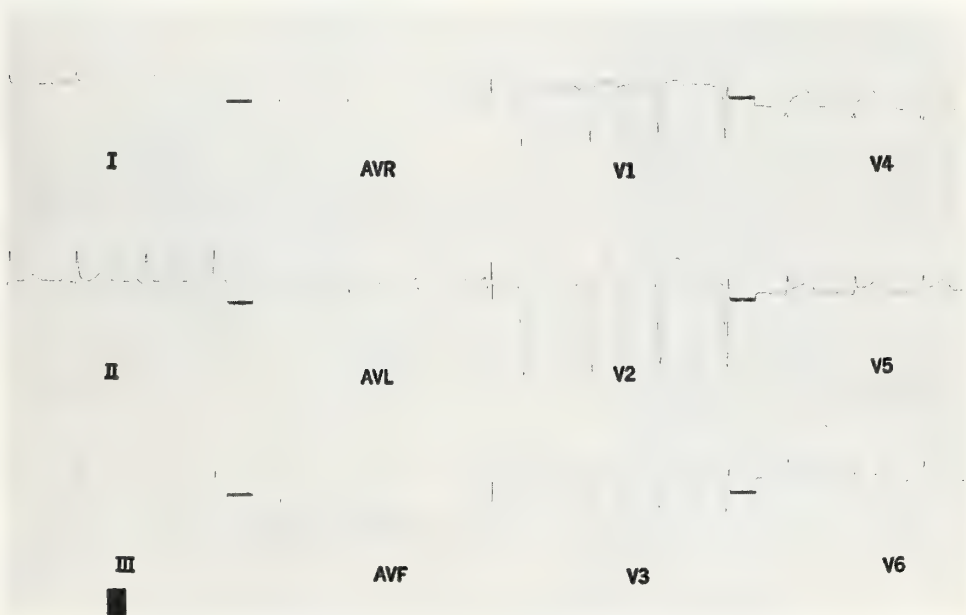
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New York, N.Y. 10017

# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a fifty-four year old woman who presented to the emergency ward after six hours of gradually worsening anterior chest pressure and pain. The pain radiated through to her back. She felt weak and somewhat dyspneic. Her blood pressure was 190/110mmHg. The lungs were clear and examination of the heart showed a loud atrial gallop (S4). Past history was negative for heart disease, although she was a heavy cigarette smoker. A chest X-ray was normal. The twelve lead ECG is shown.*



## Questions:

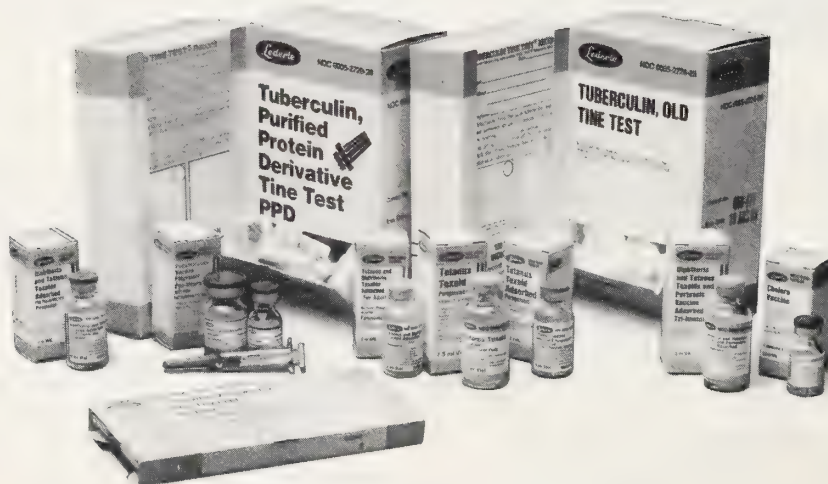
1. The ECG shows:
  - A. Intermittent accelerated idioventricular rhythm.
  - B. Atrial fibrillation.
  - C. An acute anteroseptal wall myocardial infarction.
  - D. Complete left bundle branch block.
  - E. An acute inferior wall myocardial infarction.
2. The following statement(s) is/are true:
  - A. Hypertension often accompanies an anterior wall myocardial infarction.
  - B. Bradyarrhythmias are often associated with inferior wall myocardial infarction.
  - C. Peak levels of creatine phosphokinase (CPK) following an acute infarction allow a reasonable estimate of the size of the infarction.
  - D. With the use of careful monitoring, beta adrenergic blockade could lower the blood pressure in the acute situation.
  - E. All of the above.

(Continued on page 48)





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Diplomate American Board of Radiology

**Mark Greenberg, M.D.**

Diplomate American Board of Radiology



# I M J

*Illinois Medical Journal*

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## **Treatment of Acute Myocardial Infarction With Intracoronary Infusion of Streptokinase**

BY GEORGE J. TAYLOR, M.D., F.A.C.C., H. WESTON MOSES, M.D., F.A.C.C.,  
JOEL A. SCHNEIDER, M.D., AND JAMES T. DOVE, M.D., F.A.C.C./SPRINGFIELD

*Eight patients with acute myocardial infarction received streptokinase infusion through a catheter positioned in the occluded coronary artery. Six of eight had lysis of coronary thrombus with resolution of ECG changes and chest pain. Preliminary data suggest that those with successful reperfusion of the occluded coronary artery have limitation of myocardial necrosis. The role of this therapy for large, acute myocardial infarction is reviewed.*

Extent of left ventricular injury is a major determinant of prognosis in patients with myocardial infarction (MI).<sup>1</sup> Most patients with acute MI have acute coronary artery thrombosis, and this suggests that thrombolytic therapy may have a role in limiting necrosis by reperfusing the heart muscle before irreversible damage has occurred.<sup>2</sup> Systemic thrombolytic therapy has been used in acute MI with equivocal results.<sup>3,4</sup> Rentrop first demonstrated lysis of coronary arterial thrombi using intracoronary infusion of streptokinase (SK) in patients with acute MI.<sup>5,6</sup> Streptokinase works by generating the fibrinolytic enzyme plasmin through conversion of the pro-enzyme plasminogen. Additional pilot studies of SK therapy have shown that patients who have lysis of coronary artery thrombus with reperfusion of occluded arteries have less myocardial injury<sup>7</sup> and improved regional myocardial perfusion.<sup>8,9</sup>

The purpose of this communication is to report early experience with intracoronary SK therapy

in central Illinois and to emphasize features of this therapy important in managing patients in our rural referral area.

### **Methods**

Patients less than 71 years old with acute myocardial infarction (MI) and continuous chest pain for less than eight hours were considered for this study. Electrocardiographic criteria for admission included at least 2mm ST segment elevation in two or more anterior precordial leads (anterior MI), or at least 2mm ST segment elevation in inferior leads with associated ST depression in anterior leads (inferior MI). These criteria for inferior MI including reciprocal ST depression were chosen because they select those with unusually large inferior infarction.<sup>10</sup> Exclusion criteria included history of SK allergy, previous stroke, surgical procedure within the preceding two weeks and active peptic ulcer disease.



TABLE 1							
Patient	Age	Artery	Duration pre-treatment chest pain (Hrs)	Outcome	Duration SK perfusion before recanalization (Min)	LV-EF <sup>+</sup> At Onset of MI	LV-EF <sup>+</sup> pre-hospital discharge
1	40	LAD	3.0	Reperfusion	15	32%	54%
2	66	RCA	1.5	Reperfusion	10	63%	71%
3	57	LAD	4.0	Unsuccessful	*	42%	38%
4	42	RCA	3.5	Early reperfusion, re-occlusion	35	48%	50%
5	43	RCA	2.5	Reperfusion	50	36%	41%
6	48	LAD		Unsuccessful	*	35%	20%
7	64	RCA	4.5	Reperfusion	50	30%	44%
8	64	RCA	2.5	Reperfusion	25	37%	51%

<sup>+</sup> LV-EF = Left ventricular ejection fraction  
<sup>\*</sup> These two had SK infusion for 60 minutes.

The study group includes eight male patients, 40 to 66 years old (Table 1). Five patients were seen initially in our Emergency Room. After these patients were identified as candidates for SK therapy by the primary physician, the procedure was explained to the patient and his family. Written informed consent was obtained. The protocol and consent form had been reviewed and approved by the Springfield Committee for Research Involving Human Subjects. Three patients were transferred to Springfield from outlying communities (Decatur, Lincoln, Litchfield). Streptokinase therapy had been explained to them and their families by the primary physician, and patients were transferred directly from ambulance to the catheterization suite on arrival in Springfield.

Prior to catheterization, platelet count, thrombin time, prothrombin time, partial thromboplastin time and creatine kinase were obtained. All patients received standard therapy for myocardial infarction including oxygen, antiarrhythmic therapy, morphine and continuous electrocardiographic monitoring. Two cardiologists attended the patient during the catheterization procedure.

The streptokinase infusion protocol was similar to that described by others.<sup>6-9</sup> All patients had left ventricular and coronary angiography using the femoral approach. A complete diagnostic arteriogram was considered necessary because of the potential need for revascularization surgery. After the diagnostic angiogram a coronary catheter was positioned in the ostium of the occluded coronary artery. A bolus injection of nitroglycerine, 200mg., was given in the occluded artery to exclude spasm. This had no effect on distal flow in any of the eight patients.

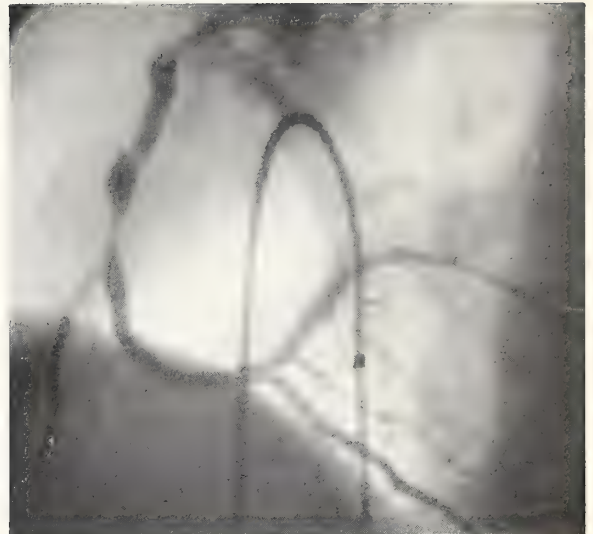
A 20,000 IU bolus injection of SK was given

over 20-30 seconds through the coronary catheter. This was followed by intracoronary infusion of SK at 4,000 IU/min (1,000 IU/ml). Infusion was interrupted at 15 minute intervals for repeat injection of the occluded artery with angiographic contrast (Renografin 76). This single injection of the coronary artery interrupted SK infusion by no more than 10 seconds. If no evidence for reperfusion was noted after 30 minutes of SK infusion a 3 F catheter was advanced through the coronary catheter into the occluded artery and positioned as close to the occluded segment as possible. SK infusion at 4,000 IU/min through the sub-selective catheter was continued for another 30 minutes. If there was no evidence for recanalization noted after a total of one hour, SK infusion was stopped and the patient returned to the coronary care unit. When reperfusion of the distal artery was accomplished SK infusion was continued for 30 minutes.

### Results

Six of the eight patients had recanalization of the thrombosed coronary artery during SK infusion (Table 1). One of them (patient 4) had re-occlusion of the artery at the end of the one hour infusion period in this case. SK infusion was continued for another 30 minutes at a rate of 6,000 IU/min yet distal flow could not be restored. Four patients (numbers 4-7) had placement of the sub-selective catheter after a 30 minute infusion of SK failed to open the artery, and two of them had dissolution of thrombus. The pre- and post-treatment angiograms from patient five are shown.

Restoration of distal flow in the thrombosed artery was accompanied by disappearance of chest pain and reduction in ST segment elevation. Rapid evolution of T wave changes and appear-



**Coronary arteriogram from patient 5 before and after streptokinase infusion. Left hand panel: totally occluded right coronary artery just beyond the tip of the catheter. Right hand panel: patent, large dominant right coronary artery following SK infusion. A pacemaker catheter had been inserted because of symptomatic sinus bradycardia.**

ance of Q waves followed as has been described.<sup>7-9</sup> Re-occlusion of the right coronary artery in patient 4 was followed by return of pain and ST segment elevation. Patient eight had coronary artery spasm at the site of a high grade right coronary stenosis at the end of SK perfusion. His recurrent pain and ST segment elevation were treated successfully with intravenous nitroglycerine and intra-aortic balloon counter-pulsation. Patient seven had an arterial blood pressure of 60/30 mmHg at the onset of SK infusion with left ventricular end-diastolic pressure of 32mmHg. In addition to the acute occlusion of the right coronary artery, he had a history of previous MI with total occlusion of the left anterior descending artery. Reperfusion of the distal right coronary artery followed SK infusion. At that time, pain disappeared, blood pressure returned to normal and dopamine therapy could be stopped.

Patients 4, 6 and 7 were transferred directly from other hospitals. Two had dissolution of thrombus and one had re-occlusion as noted above. As a group they tended to receive SK infusion later than those seen initially in our emergency room. Time in transit for these three was 32, 40 and 45 minutes respectively. While they were in transit the catheterization laboratory was

being prepared, a process that takes 20-30 minutes. As noted above, these patients were brought directly from ambulance to the catheterization suite. Each of these patients presented to hospital with acute infarction within 30 minutes of the onset of chest pain. Their delay in getting to the catheterization laboratory when compared with local patients was thus related to delay in identifying them as candidates for SK infusion and not to transport time. Two of the three were in the hospital for more than two hours before SK therapy and transfer were considered. One of these three patients had ventricular fibrillation while in transit. This was electrically cardioverted by paramedical and nursing personnel in attendance.

The six patients with restoration of distal flow with SK infusion all had severe stenoses at the origin of thrombus with narrowing of the artery by more than 90%. Four had multi-vessel and two single vessel coronary disease. Patient four with temporary reperfusion had single vessel disease; the other patient with single vessel disease had a 95% narrowing which appeared ulcerated in a large, dominant right coronary artery. Re-vascularization surgery was recommended for the five patients whose reperfused arteries remained patent. Aorto-coronary bypass surgery was accomplished within three days of SK infusion



without incident. Four patients were treated with heparin until 12 hours prior to surgery; clotting studies had returned to normal just before operation. The fifth had surgery one hour after SK infusion because of coronary spasm that waxed and waned. These five patients were discharged from hospital 7-10 days post-operatively, within two weeks of myocardial infarction. Those with successful SK therapy and subsequent revascularization surgery had either normal or improved LV ejection fraction at the time of hospital discharge (Table 1). Those without reperfusion had little change in ejection fraction.

### Complications

The angiographic catheter was left in the femoral artery for 24 hours after SK infusion in order to minimize hematoma. Three patients had sizeable hematoma at the site of catheter insertion, but none required drainage. One patient had a single episode of hematemesis eight hours after SK infusion which did not recur; for this reason heparin therapy was discontinued. One patient with a history of claudication and absent foot pulses at the time of initial evaluation had worsening ischemia of the lower leg following catheterization. For this reason he had peripheral arterial bypass surgery at the time of his coronary revascularization procedure; the foot pulse was restored. With reperfusion, three of the six patients had ventricular premature beats (VPB's) which were easily controlled with Lidocaine therapy. One additional patient had an episode of ventricular fibrillation with persistent VPB's despite Lidocaine infusion. In addition to DC cardioversion he also was treated with bretylium tosylate with resolution of arrhythmia.

### Comment

These findings are in agreement with other pilot studies showing that acute coronary thrombus can be dissolved using SK infusion in about two-thirds of patients with acute MI. Furthermore it is apparent from this and other studies that recanalization of the occluded artery leads to disappearance of chest pain and probable reduction of myocardial injury (Table 1).<sup>7</sup> Patients with acute MI often have severe and diffuse coronary artery disease.<sup>1</sup> With limitation of myocardial necrosis they are better candidates for revascularization surgery, and prognosis may be improved. Obviously, streptokinase does not always effect dissolution of coronary thrombosis. This

may be due to the extent of the underlying vascular occlusive disease, the presence of chronic occlusion, plasmin levels or technical factors in delivery of the drug to the site of obstruction.

This study does demonstrate that patients within our referral area can be transferred from out of town to the catheterization laboratory with relative speed and safety. All three transfer patients received SK therapy well within the time considered critical for coronary recanalization and myocardial preservation.<sup>7</sup> The major delay in getting them and local patients to the catheterization laboratory is delay in recognizing them as candidates for SK treatment. This seems unavoidable with a new therapy. It must be emphasized that patients being transferred with acute MI must have personnel, equipment and telemetry needed to handle serious arrhythmia available during transport.

We emphasize that these and similar results are preliminary. The precise role of this therapy in treatment of acute MI is unknown and requires controlled and randomized trials. Our own data suggest that streptokinase therapy may be applicable in rural Illinois. ◀

### Addendum

Since the submission of the manuscript, 40 patients with acute infarction have been treated with intracoronary SK infusion. Recanalization of the occluded artery was noted in 36 of the 40 patients (90%). Five patients whose arteries opened initially re-occluded. Thus, 31 of 40 (77.5%) had successful interruption of MI with intracoronary SK therapy. All of those successfully treated survived. One patient with anterior infarction whose occluded artery did not open after infusion of SK died in cardiogenic shock.

### Acknowledgement

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**George J. Taylor, M.D.**, was trained in medicine and cardiology at the Johns Hopkins hospital where he also served as chief resident in medicine and assistant professor of medicine. He served as assistant professor of medicine and cardiology at the University of Virginia prior to coming to Southern Illinois University, where he is a clinical associate professor of medicine.

**H. Weston Moses, M.D.**, obtained his medical degree from the University of Virginia. He completed internal medicine internship and residency at Yale University. His cardiology training was at the University of Rochester where he remained on the faculty as assistant professor of medicine. He is currently practicing cardiology in Springfield, Illinois and is a clinical associate professor of medicine at Southern Illinois University.

**Joel Schneider, M.D.**, a graduate of the University of Michigan Medical School, did his medical internship at the University of Michigan in Ann Arbor. His general surgical residency was done at the University of Michigan and he completed his training in cardiovascular and thoracic surgery at the University of Virginia. He currently is a clinical associate professor of surgery at Southern Illinois University and chairman of the department of thoracic surgery at St. John's Hospital, Springfield.

**James T. Dove, MD.**, is a graduate of Case Western Reserve University. He did his medical training at Mt. Sinai Hospital in New York where he also was chief resident in medicine. His cardiology training was completed at the University of Rochester, Strong Memorial Hospital. Currently he is a clinical associate professor of medicine at Southern Illinois University.

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# Case Reports

## Esophageal Intramural Pseudodiverticulosis

BY ROBERT GREENSTEIN, M.D. and HARIVADAN V. SHAH, M.D./EVANSTON

*This patient presented with dysphagia associated with a stricture and pseudodiverticulosis of the esophagus. This case is unique because it is the first to be reported of these features associated with an obstructing congenital band. The band was found at surgery after esophageal dilation failed to relieve the patient's symptoms.*

Intramural diverticulosis of the esophagus was first described by Mendl, *et al*, in 1960.<sup>1</sup> Since then, 41 cases have been reported.<sup>2</sup> Recently, Muhletaler, *et al*, reviewed 36 cases and described five new cases.<sup>2</sup>

No definite cause of this condition has been found, but some have been associated with stricture formation, either proximal or distal, or at the level of the diverticula.<sup>3</sup> The case described by Hodes and coworkers did not have strictures.<sup>4</sup> When a stricture of the esophagus was found associated with the diverticulosis, a cause and effect relationship was not established. Associated monilial infection<sup>4-6</sup> and reflux esophagitis<sup>7</sup> have been found in some cases.

Radiographic findings are typical and well described. Multiple smooth, flask shaped out pouchings of the esophageal lumen are seen on barium swallow. Involvement of the esophagus may be diffuse or localized.

Under endoscopy, nonspecific inflammatory changes may be seen with stricture formation. The openings of the glands may or may not be seen. Sometimes the esophagus looks entirely normal.

At pathology, the "diverticula" have been found to be dilated pre-existing glands of the esophagus.<sup>8-10</sup>

### Case Report

A 32 year old white female was seen in the emergency room with a history of projectile vomiting and choking sensations in the throat and chest of one week's duration. History revealed food intermittently stuck in her throat with occasional vomiting during the past seven years. At age four, she had poliomyelitis, which left her paraplegic. She had a history of hiatus hernia for approximately 17 years, with post-prandial heartburn, for which she was receiving antireflux treatment. Physical exam showed flaccid paraplegia and leg muscle atrophy. No other findings were noted.

On the first barium swallow examination, barium did not go beyond the level of the fifth thoracic vertebra. The esophagoscope could not be passed beyond 25cm. No mucosal lesion was noted. A repeat examination showed slight dilatation of the proximal third of the esophagus, with a gradual tapered stricture at the level of the manubrium and

multiple pseudodiverticula affecting the middle and distal esophagus, associated with esophageal spasm. There was a moderate size hiatus hernia, and reflux was noted. After multiple attempts at dilatation failed, a thoracotomy was performed. It showed a fibrous band across the anterior aspect of the esophagus at the junction of the middle and upper third, producing constriction of the upper esophagus. Mobilization of the esophagus and transection of the band were done. The patient's symptoms improved after surgery, and a repeat barium swallow revealed a normal caliber of the esophagus with persistence of pseudodiverticula.

A biopsy taken at the time of esophagoscopy showed evidence of acute and chronic inflammation.

### Discussion

Review of the literature showed no case of esophageal pseudodiverticulosis associated with extrinsic narrowing of the esophagus. Most cases showed intrinsic stricture formation. Our patient also had long-standing hiatus hernia with reflux. Since pseudodiverticulosis is associated with esophagitis, as well as stricture formation, when a stricture is demonstrated and difficult to dilate, the cause, as in this case, may be due to extrinsic factors rather than intrinsic disease.

The nonspecific inflammatory changes, as described in the previous reports, were found in our case, although secondary monilial infection was not found. Our patient had long-standing dysphagia and associated



**Robert Greenstein, M.D.**, is a board certified radiologist affiliated with St. Francis Hospital in Evanston. A clinical instructor for the Loyola University Stritch School of Medicine, Dr. Greenstein cites particular interest in ultrasound.

**Harivadan V. Shah, M.D.**, is a diagnostic radiologist affiliated with St. Francis Hospital in Evanston.

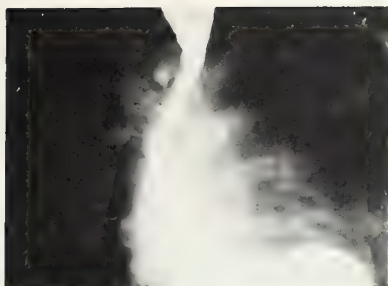


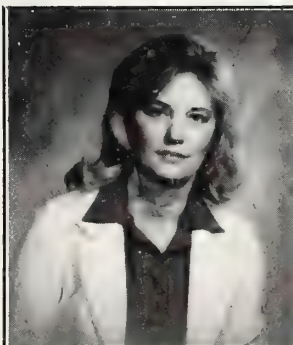
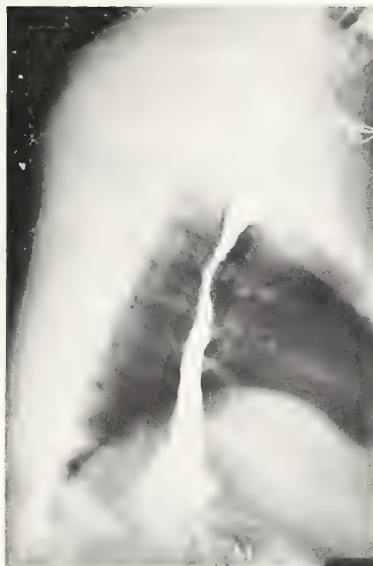
Figure 1

AP and lateral radiographs of barium swallow show multiple intramural pseudodiverticula in the stricture of midesophagus; hiatus hernia is also seen.

hiatal hernia with gastroesophageal reflux, which has been typical in previously reported cases.<sup>7</sup>

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# Case Reports

## Supernumerary Ovary

BY PEDRO A. POMA, M.D., F.A.C.O.G., F.A.C.S./CHICAGO

*Less than a dozen supernumerary ovaries have been reported. A new case associated with cystic teratoma, corpus luteums, uterine leiomyomas and duplication of the urinary collecting systems is described. The clinical implications of this diagnosis are presented.*

Supernumerary ovary is a rare gynecological entity. There are less than a dozen documented cases in the literature. At present there are no available means for a preoperative diagnosis. The diagnosis of a supernumerary ovary usually is done at the operating table, although it can be suspected when there is evidence of continued hormonal functioning in a patient following bilateral oophorectomy.

Kosasa, *et. al.*,<sup>1</sup> reported a case in which a supernumerary ovarian function was demonstrated preoperatively by human chorionic gonadotropin stimulation; this patient had shown evidence of persistent ovarian function.

Still, when more than two ovaries are noted at laparotomy or when ovaries are encountered following bilateral oophorectomy, the task is to differentiate a supernumerary ovary from a simple accessory ovary. Supernumerary ovaries have been considered clinically to be enlarged lymphatic glands or mesenteric, omental, retroperitoneal, para-aortic or pelvic masses of unknown etiology. And in most instances, the histological findings of ovarian stroma

and follicles are unexpected.

### Case Report

A 50-year-old, white professional dancer, Para 2012, was admitted to Mount Sinai Hospital Medical Center of Chicago. For about 3 years before her admission, her menstruations had become heavier, lasting 8 days. Seven months before admission a fractional curettage yielded benign endometrial tissue. This patient's menarche had occurred at 10 years of age; her menstruations had been regular (3/28 days). Her last delivery was in 1953, and her last menstruation had begun three weeks before this visit. She had relied on withdrawal for contraception. Her current cervical cytological exam was normal. She recalled that a skin carcinoma was removed in 1970.

On admission, her weight was 61.4 kg, her height 155cm; and her vital signs and preoperative laboratory evaluation were within normal limits. During abdominal examination, an 11cm suprapubic irregular mass, which corresponded to the uterus at pelvic examination, was noted. A barium enema was considered normal and the presence of the pelvic

mass described. On April 29, 1977 with the preoperative diagnosis of uterine fibroids, a laparotomy was performed. The ovaries were larger than average (5 x 6cm); the right and left ovaries were noted in normal position attached by the utero-ovarian ligaments. A left "superior" ovary was also noted in proximity to the infundibulopelvic ligament (Figures 1, 2). Figure 3 depicts the intravenous pyelogram.

The final pathological diagnoses were: uterine leiomyomas and adenomyosis; secretory endometrium; chronic cystic cervicitis; right ovarian corpus luteum and cystic teratoma, and left "inferior" and left "superior" ovaries with corpus luteum. The 3-year, post-operative follow-up on this patient was unremarkable.

### Comments

According to Wharton,<sup>2</sup> an ovary (follicles and stroma) is considered *supernumerary* when it is entirely separated from the normally-placed ovary. It apparently arises from separate primordium. There is a high incidence of other malformation with supernumerary ovary. As in the case presented here, many of Wharton's cases (75%) had urinary malformations.

An *accessory* ovary is situated near the normally-placed one and may be connected to it. The accessory ovary often seems to have developed from its companion. Accessory ovaries occur more frequently than supernumerary ovaries. Early reports indicate their presence in about 3% of

**PEDRO A. POMA, M.D.**, is a board certified obstetrician and gynecologist affiliated with Mount Sinai and Gottlieb Memorial Hospitals and Rush Medical College. He is a former director of the OBGYN Clinics at Cook County Hospital. He is also a lecturer at the Cook County Graduate School of Medicine, and a trustee, Chicago Medical Society.

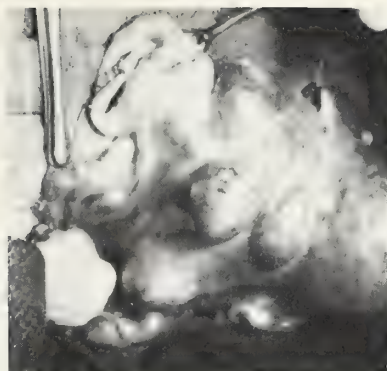


Figure 1

The large leiomyomatous uterus is noted. The Russian forceps holds the left fimbria. The Babcock forceps holds the left "inferior" ovary. The left "superior" ovary is seen in position.



Figure 2

The ovaries are seen following hysterectomy. The Russian forceps hold the left "superior" ovary. The other two ovaries are seen in position.

routine autopsies. Accessory ovaries are also associated with a lower incidence of malformations (26%).<sup>2</sup>

Supernumerary ovaries have been described in the same locations in which germ cells spend part of their embryonal life and from which they normally migrate. Wharton<sup>2</sup> postulated that if any of the germ cells fail to migrate, continuing to live and multiply in any of these areas, and if the surrounding mesenchyme is transformed into ovarian stroma, a supernumerary ovary results.

## Review of Literature

In 1864 Grohe described the first supernumerary ovary following an autopsy on a 40-year-old woman. A third ovary was lying in a plication of the pelvic peritoneum on the left

side. Wharton in his extensive review<sup>2</sup> (1861-1959), because of the brevity of Grohe's report, disregards it as a true case of supernumerary ovary. Therefore, Winckel's 1890 report is accepted as the first documented case.

Wharton described a patient with 6 potential ovaries, 4 of which had been confirmed histologically. The supernumerary ovaries exhibited the same functional and pathological capabilities as in normally placed ovaries. The literature contains reports of the whole pathological spectrum of tumors similar to those found in normally placed ovaries. It also contains reports of tumors commonly derived from ovaries, in addition to the two normally placed ovaries. In some cases these tumors contain ovarian tissue; in other cases they do not.

The incidence of benign cystic teratomas has been reported in 5 to 20% of ovarian neoplasias; the bilateral nature of the tumor varies from 12-25%.<sup>3</sup> Of 26 reports of tumors in addition to the two normally placed ovaries, 23% were cystic teratomas (one of them malignant).<sup>2</sup> Our patient presented a cystic teratoma of the right ovary.

It is worth noting that, as in the case presented here, most of the supernumerary ovaries described in the literature presented corpus luteum. The supernumerary ovaries were functional. The literature review does not yield a previous report involving supernumerary ovaries and uterine leiomyomas. This association was noted in this patient, a 50-year-old woman with regular menstruations since the age of 10.

In view of the high association of supernumerary ovary with congenital malformations, especially of the urinary tract, and the possibility of benign and malignant transformation of the supernumerary ovaries, this diagnosis has more importance than as a medical oddity.

The presence of supernumerary ovary is particularly frustrating, for example, when bilateral oophorectomy is performed as a hormonal ablative procedure in the case of advanced breast carcinoma.<sup>1</sup> Delay in the recognition of this unusual entity arises from the common clinical observation of vasomotor symptoms despite the presence of additional



Figure 3

Intravenous pyelogram demonstrating bilateral duplication of the renal collecting systems.

ovarian tissue following bilateral oophorectomy. The vasomotor symptoms in these instances are probably due to the surgical trauma.

When the uterus is present, the resumption of menstruation leads the physician to consider the possibility of primary uterine pathology or incomplete ovarian tissue removal. When the uterus is absent, the presence of additional ovarian tissue might not be discovered as early. Symptoms of pressure or clinical signs of an enlarging mass are usually late symptoms and signs. The first evidence of the presence of additional ovarian tissue may be metastatic disease. However, the hormonal nature of the mass, if suspected, may be identified by endocrine studies.

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# Surgical Grand Rounds

JOHN M. BEAL, M.D. AND JULIUS CONN, JR., M.D., CONTRIBUTING EDITORS

*Surgical Grand Rounds are held weekly on Tuesday, at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of December 2, 1980.*

## ***Associated With Paroxysmal Nocturnal Hemoglobinuria***

### **Intestinal Obstruction**

**DR. LISA BAILEY:** This 44-year-old white male has a history of paroxysmal nocturnal hemoglobinuria with pancytopenia and coagulation problems. He has been treated with transfusions every month, receiving four units of washed packed red cells.

His past medical history includes a small bowel obstruction which was treated conservatively with a Cantor tube. He was recently discharged after an episode of pleuritic chest pain and suspected pulmonary embolism. The investigation, which included a pulmonary angiogram, was negative. He also has a history of venous thromboses over the last two years with one episode of priapism which required decompression. He was treated with Coumadin® which had to be stopped because of gastrointestinal bleeding. He has had recurrent infections at sites of intravenous therapy and phlebotomy. His medications include prednisone and cimetidine.

This present admission was initiated by the onset of severe midabdominal cramping pain followed by multiple episodes of bilious emesis. His last bowel movement was one day prior to ad-

mission.

Physical examination revealed that he was thin, in moderate abdominal pain, afebrile with no orthostatic pulse or blood pressure changes. His abdomen was distended and diffusely tender, with hyperactive bowel sounds. His rectal exam was negative. He also had some cellulitis over the lateral and dorsal aspects of his right foot and small petechial spots, especially on his face. His hemoglobin was 13.0gm. and his white blood count was 2900 with a platelet count of 20,000/cu.mm. His abdominal films revealed dilated loops of the small bowel.

A Cantor tube was passed, but over the next few days his pain and tenderness centered primarily on the left side of his abdomen, lateral to his umbilicus. He had occasional bowel movements, as well as passage of flatus. Hyperalimentation was begun because of the long course of his problem and previous marked weight loss.

**DR. SIEGFRIED HOLZ:** Films of the abdomen were obtained following admission to the hospital. Multiple air fluid levels were demonstrated on the upright examination of the ab-



domen which suggested mechanical small bowel obstruction. After passage of the Cantor tube, there was considerable improvement although scattered segments of dilated small bowel remained.

**DR. LISA BAILEY:** He continued to show evidence of partial small bowel obstruction and, after 15 days, a laparotomy was performed. Multiple adhesions were found, causing the partial small bowel obstruction. The greater omentum was stuck to the parietal peritoneum. There were multiple adhesions from the ligament of Treitz to the ileocecal valve. One especially thick adhesion near the ileocecal valve was sent to pathology and showed hemosiderin deposit. Hemorrhage was not a problem during surgery. Postoperatively, in the recovery room, his urine output dropped and turned dark. A diagnosis of hemolysis and hemoglobinuria was made. He was treated with fluids and mannitol. He left the hospital three weeks post-operatively.

#### Literature Review

Paroxysmal nocturnal hemoglobinuria (PNH), also called the Marchiafava-Micheli Syndrome, was first described by Strubing in 1888. The disease is characterized by red blood cells which are abnormally sensitive to the lytic action of serum complement. There is, however, probably more to this disease than lysis, with some bone marrow abnormality and either abnormal and/or deficient production of all three cell lines. PNH has been considered by some as a myeloproliferative disorder.

The red blood cells are unusually sensitive to the lytic action of complement, either through the classic or the alternate pathway. Serum complement can be activated by a number of factors: (1) acidification of the serum which can be used to test for this condition; (2) antibody formation which is not really found in these patients; (3) cobra venom. When a complement is active, red blood cells in these patients are hemolyzed, while normal red blood cells are not hemolyzed. In normal patients, there is a single population of red blood cells. In PNH patients, there may be two or three cell populations, with varying degrees of susceptibility to hemolysis. These cell populations may exist in any proportion, and, therefore, the course of the illness may vary from patient to patient depending upon the proportion of these abnormal blood cells. This suggests that there may be a problem with the stem cells because of the number of different lines and different abnormalities. The defect which makes them susceptible to lysis by complement occurs in the red cell membrane, which allows more  $C_3$  to attach

to the membranes than to those of normal red cells, allowing more lysis to occur.

In the bone marrow, the proportion of abnormal precursors to normal precursors is increased because the cells do not last as long in the serum secondary to the hemolysis. Therefore, the bone marrow is busy creating abnormal cells. The hemoglobinuria which is seen in these patients varies depending on the number of abnormal cells and the degree of abnormality.

The membrane of the platelets in these patients also seems to be defective and is more easily lysed than in the normal platelets. This only partly explains the degree of thrombocytopenia that these patients manifest. Also, it should be noted that even in those patients with thrombocytopenia, the complications that occur are usually thrombotic and may be related to the complement activation.

The white blood cells in these patients are frequently defective, usually susceptible to lysis by complement, and may also function abnormally. These patients are frequently leukopenic, as well.

The cause of this disease is not known. It is not inherited. Possibilities include drugs or environmental factors, but evidence is lacking. The presence of bone marrow dysplasia suggests some type of injury to the marrow. Most patients will have irregular episodes of hemoglobinuria with episodes lasting for several days. Some postulate an infectious, especially viral, etiology. Transfusions of whole blood or plasma may also trigger hemolysis and hemoglobinuria, as will surgery or strenuous exercise.

The disease is rare and insidious in onset. The peak age of onset is between 25-45 years of age, without sexual predilection. Clinical manifestations include hemoglobinuria which occurs as the original manifestation in about 25%. It occurs primarily at night. The suggested reason is that sleep causes  $CO_2$  retention and decreased pH level in the serum causing complement activation which then causes lysis. This has not been proven. We had an arterial line in our patient for two or three days and could not demonstrate acidosis whether he was awake or asleep. Other considerations include circadian rhythms of complement and cortisol excretion. It has been noted, however, that when people with PNH reverse their sleep patterns so that they sleep during the day and stay awake during the night, their hemoglobinuria occurs during the day.

Chronic hemolysis is the most common presentation for these patients and may be the only manifestation. Thus, the diagnosis of PNH may be delayed. Thrombocytopenia occurs in about 66% of PNH patients and leukopenia in about

60%. There may frequently be an iron deficiency also. Administration of iron increases the number of abnormal cells that the bone marrow makes but this increases hemolysis.

One of the main problems that these patients have is venous thrombosis. Hepatic-vein thrombosis with resultant Budd-Chiari syndrome is not uncommon. Headaches, which are also common, may be secondary to small vein thromboses. More major venous thromboses may occur also. Thromboses of the splenic vein, the portal vein and the mesenteric vein can also occur. They are especially common during hemolytic crisis, childbirth and abdominal surgery. These are sometimes attributed to a hypercoagulable state induced by intravascular hemolysis. More likely, platelets are activated by complement and aggregate, causing thrombosis of the veins.

Occasionally, patients with PNH will present with isolated symptoms of abdominal or low back pain and may have abdominal pain with tenderness and rebound tenderness. Rarely, infarction of the intestines may occur.

Some patients will also have retrosternal fullness which occurs with attacks of hemoglobinuria secondary to esophageal spasm. Renal damage is rare unless the patient becomes dehydrated or hypertensive during a hemolytic crisis.

Tests which can be used to help in the diagnosis include blood counts. Microcytic hypochromic anemia, increased reticulocyte count and decreased white blood cell count, especially granulocytopenia, occur. Platelet count is low. Bone marrow biopsy shows erythroid hyperplasia, frequently with dysplasia and decreased cellularity. The urine may or may not contain hemoglobin, but usually it contains hemosiderin and may contain hemoglobin casts.

Tests which can be used include the acidified serum or Ham test, or, as it might be called, the "acid test," for serum that is acidified and incubated. This is not sufficiently sensitive for patients with low numbers of abnormal cells. Another test which can be used is the sucrolysis test. Coombs tests, direct and indirect, are usually negative, though occasionally can be positive.

### Treatment Regimen

The treatment is primarily symptomatic and related primarily to hemolytic or thrombotic episodes. Transfusion is useful for two reasons: (1) it increases oxygen carrying capacity and (2) suppresses bone marrow. Iron may be given these patients, if they are being transfused and marrow is being depressed. Otherwise, hemolysis occurs. Some patients benefit from high doses of androgen. Steroids may be helpful in preventing hem-

olysis, even after the initial dose. Sometimes the dose has to be fairly high. This patient was receiving 20mg. prednisone per day and it did not prevent his hemolytic crisis. Coumadin does not affect hemolysis, but can be effective in preventing thromboses. It is not helpful for already established thromboses. Heparin may actually initiate hemolysis in these patients and should not be used. Splenectomy is not beneficial. Dextran may reduce or cease hemolysis and hemoglobinuria; usually 500-1000cc. of a 6% solution is used. The effect is temporary, however, and there are problems with repeated usage of dextran. Therefore, in long-term therapy, dextran is not particularly useful. Bone marrow transplantation for these patients has been suggested as being curative if an HLA identical person can be found.

As far as the prognosis goes, in about half of these patients the number of abnormal cells decreases over months to years. This is usually a chronic disease. The main points for surgeons to remember are (1) do not remove the patient's spleen; (2) make sure the patient is well ventilated to prevent CO<sub>2</sub> retention and secondary acidosis; (3) The patient should be kept well hydrated. If hemolysis does occur, which it frequently does after operations, adequate hydration may prevent renal failure; (4) The patient may benefit from platelet transfusion, preferably from a matched donor, and, if transfusion is necessary, use only washed red blood cells (plasma and whole blood will cause hemolysis); (5) Coumadin may help to prevent thrombotic complications, but is not effective with existing thromboses. *Do not use heparin.* (6) Extra care to avoid infections in leukopenic patients is extremely important.

**DR. GABRIEL LORENZO:** One of the main problems with patients suffering this disorder is obtaining properly typed and cross matched blood. As a result of numerous previous transfusions, these patients develop antibodies that make cross match extremely difficult. Because whole blood transfusions can precipitate a hemolytic crisis, it is preferable to use washed saline red cells. Another interesting hematologic problem is the thrombocytopenia that is present in a significant number of patients suffering from PNH. For reasons unknown, reported fluctuations in the platelet count have been reported. As an example, this patient ran a platelet count of 15,000 to 16,000 during his hospitalization, and, on the day of the operation, the platelet count rose to 30,000.

**DR. JOHN BEAL:** Was there much bleeding when you made the incision?

**DR. GABRIEL LORENZO:** Not really. We went through a midline incision and the amount



of bleeding was moderate.

**DR. NADIM KHOURY:** This particular patient had a bout of prolonged obstruction in April and, in this respect, I think he probably either perforated his bowel or he did bleed. We elected not to operate on him at that time because he was quite critical. I would like to add several points to Dr. Bailey's description. Although this disease is considered rare, it is probably not as rare as the literature suggests. I think many of the mild cases are being missed. Any time you find a patient with unexplained anemia, whether it is aplastic, hemolytic or what-have-you, you should do a Ham test or some other test to determine PNH. You would be surprised that you might pick up some of the very mild cases. Currently, the etiology of the disease is unknown, but most of the people who have any experience with it believe that it is a disease of the stem cell. It is probably an acquired disease of viral infection in which the stem cells are undergoing mutation and all the three elements of the blood including the red cells, the white cells and the platelets get affected—the red cells more than the other cells. Eventually, if the patients live long enough, some will enter into a complete remission. Many of these patients, if they do live long enough, will terminate with acute leukemia. A word of caution, as Dr. Bailey said. We do not feel that iron is of any value. I think if you give iron to the patient, it will be wasted, and it often causes an acute hemolytic crisis. Of course, you should not use heparin and you should always use washed blood cells.

**DR. JAMES HINES:** What usually brings these people to the doctor?

**DR. NADIM KHOURY:** Most of them come because of symptoms of anemia. They get weak, they get tired, etc. Occasionally, what brings them to the doctor is thrombotic complications, phlebitis or arterial thrombosis. However, the most common reason is anemia. ◀

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## Clinics for Crippled Children Listed for August

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 21 general clinics, 11 cardiac clinics, one for children with neurological problems, and 1 for children with myelodysplasia. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- 2 Peoria Myelodysplasia - St. Francis Medical Center
- 3 Maryville - Oliver C. Anderson Hospital
- 3 Park Ridge General - PM - Lutheran General Hospital
- 3 Park Ridge Cardiac - AM - Lutheran General Hospital
- 3 Wheaton - Marianjoy Rehabilitation Hospital
- 5 Hinsdale - Hinsdale Sanitarium
- 5 Lake County Cardiac - Victory Mem. Hosp.
- 5 Metropolis - Massac Memorial Hospital
- 6 Division Cardiac - U. of I. at the Medical Center
- 9 Belleville - Belleville Memorial Hospital
- 9 Peoria Cardiac - St. Francis Medical Center
- 9 Maywood - (Ortho/Ped/Neuro) - Loyola Medical Center
- 9 Chicago Heights Cardiac - St. James Hosp.
- 10 East St. Louis - Community Hospital
- 10 Peoria General - St. Francis Medical Center
- 11 Rockford - St. Anthony Hospital
- 11 Joliet - St. Joseph's Hospital
- 11 Chicago Heights General - St. James Hospital
- 12 Aurora Cardiac - Mercy Center for Health Care Services
- 12 Kankakee General - St. Mary's Hospital
- 16 Maywood (Ortho/Ped) - Lutheran Gen. Hosp.
- 17 Rock Island General - Moline Public Hosp.
- 18 Springfield Ped-Neuro - Memorial Med. Bldg.
- 18 Aurora General - Mercy Center for Health Care Services
- 19 Elmhurst Cardiac - Memorial Hospital of DuPage County
- 19 Rockford - Rockford Memorial Hospital
- 19 Bloomington - Mennonite Hospital
- 20 Kankakee Cardiac - St. Mary's Hospital
- 23 Peoria Cardiac - St. Francis Medical Center
- 23 Chicago Heights Cardiac - St. James Hospital
- 25 Elgin - Sherman Hospital
- 25 Chicago Heights General - St. James Hospital
- 26 Champaign Children's Home - Champaign
- 30 Peoria Cardiac - St. Francis Medical Center

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

# Sports Medicine

*The increased incidence of sports-related injuries has paralleled the fitness boom and the tremendous rise in participation in athletic competition. Treatment of such injuries has become part of the practice of a rapidly-growing number of physicians. At the same time, school boards and others responsible for athletic programs are exhibiting heightened interest in injury prevention and treatment.*

*This is the second in a series of articles prepared under the direction of the ISMS Sports Medicine Committee that will focus upon clinical sports medicine topics and related issues. The series is intended to broaden clinical knowledge, aid the physician in educating patients on preventive measures and, hopefully, stimulate physician involvement in activities designed to protect the health of young athletes. The Committee welcomes your comments and suggestions.*

## *Their Place In The Health Care System*

### **The Athletic Trainers**

BY H. BATES NOBLE, M.D., MARIANNE PORTER, M.A., A.T.,C.,  
DAVID C. BACHMAN, M.D., THOMAS H. FAGAN, M.S., R.P.T., A.T.,C.  
AND RICHARD L. HOOVER, M.S., R.P.T., A.T.,C./CHICAGO

Few physicians understand the role of an athletic trainer or know how to work effectively with one. In the past, athletic trainers have been primarily associated with professional teams and major university athletics. Only rarely did physicians treat a high school athlete whose school had the services of a certified athletic trainer. For the most part, responsibility for the prevention and immediate care of athletic injuries fell to the coaching staff, which ordinarily has neither the educational foundation in this area nor the freedom from other duties to devote full attention to the health of the athlete.

We are now seeing the advent of trainers at the high school level. A recent study conducted by the Center for Sports Medicine of Northwestern University Medical School indicated that 47.8% of the boys' interscholastic athletic programs in the Chicago area have athletic trainers on either a part-time or full-time basis.<sup>1</sup> School administrators, concerned with existing inadequacies in their present health care systems, are taking steps to rectify the situation. Recognizing an obligation to their student-athletes to provide opportunity for maximum participation without compromise of immediate or long-range health, schools are turning to the athletic trainer for injury

prevention and management programs. The threat of liability has played no small role in this decision.

More physicians will be coming into contact with athletic trainers as their numbers and job openings proliferate. In order to insure continuity in the provision of health care to the student-athlete, the physician and athletic trainer must develop a good working relationship. Trainers function in a paramedical role under the supervision of physicians. It is important, therefore, that physicians understand the educational and practical background, capabilities, and duties of certified athletic trainers.

#### **History**

The original athletic trainers were ancient Greeks working with runners during the first Olympics. They were concerned with proper conditioning, diet and rest, similar in this respect to present day trainers. Subsequent development of athletics in Athenian society saw involvement of the medical gymnastai whose responsibilities were to condition the athlete and the paidotribai ("youth or boy rubbers") and aleiptes ("anointers") whose concerns included massage, diet, and general fitness.<sup>2</sup>



Athletic competition suffered a decline after the fall of the Roman Empire and did not see a large scale rejuvenation until the latter part of the nineteenth century, when intercollegiate athletics blossomed. Many of the "trainers" were literally hangers-on whose main function was massaging the athletes with various foul-smelling ointments. The responsibilities of trainers expanded through the years, but the competence of these individuals varied tremendously.

In 1951, a number of trainers, realizing the need for professional upgrading of athletic training, met in Kansas City to found the National Athletic Trainers Association. The NATA, a voluntary professional organization, has become the certifying body for athletic trainers. Four distinct routes to certification were identified by the NATA: undergraduate or graduate curricula, apprenticeship, physical therapy, and special consideration. Within the special consideration category are experimental programs, including faculty athletic training programs such as have been developed by Northwestern University and the Sports Medicine Division of the North Carolina Department of Public Instruction. A standard educational base was developed as a preparatory foundation for prospective athletic trainers.

Sixty-one undergraduate and eight graduate programs now exist nationally to prepare athletic trainers.<sup>3</sup> These curricula have been developed in close cooperation with the medical profession, and the efforts of the NATA were recognized by the AMA House of Delegates in 1969. Behavioral objectives for educational programs must be met in the following areas: human anatomy, human physiology, human physiology of exercise, applied human anatomy and kinesiology, psychology, human growth and development, first aid and safety (including CPR), nutrition, remedial exercises, and/or special or adaptive physical education, personal, school and community health and finally, athletic training principles and techniques.<sup>4</sup>

Recommended courses to complement the athletic training curriculum include organization and administration, sports psychology, tests and measurements, coaching techniques and the regular physical education curriculum, as well as physics, chemistry, pharmacology and pathology in related disciplines.

Curriculum graduates must also complete an 800 hour practical experience in athletic training.

Alternate routes to certification include an 1800 hour apprenticeship under a certified athletic trainer, a 600 hour experience for graduates of a

physical therapy program, or completion of a faculty athletic training program. Individuals who have been active in athletic training for a minimum of five years may receive special consideration to become certified under certain circumstances, although this route is becoming increasingly unusual.

All candidates for certification by the NATA must have, at minimum, an undergraduate degree from an accredited institution, must pass a written and oral-practical examination covering all facets of athletic training, and must pledge to adhere to a strict code of ethics.

### **Duties of the Athletic Trainer**

The trainer's role is multi-faceted. His/her responsibilities are not confined to emergency first aid alone, but can also encompass the following duties.

- (1) With the coaching staff, development and implementation of a conditioning program for all athletes. With the team physician, remediation of any detected strength or flexibility deficits via an appropriate pre-season conditioning program for those individuals.
- (2) With the coaching staff, selection, fit, and proper maintenance of adequate and appropriate athletic equipment.
- (3) Inspection of playing sites and locker rooms for elimination of hazardous conditions.
- (4) With the physician, advice to athletes and coaches on matters related to conditioning and performance, including diet, rest, and rehabilitation.
- (5) With the physician, establish liaison with emergency medical services. Establish chain-of-command and plan strategies for immediate care of serious or multiple injuries.
- (6) Availability to: (a) apply necessary taping, wrapping, padding, braces and (b) recognize and evaluate all injuries, determine nature and severity, provide necessary and appropriate first aid, with physician (when available) make judgments regarding continued participation, refer significant pathology to emergency room or physician for diagnosis and treatment.
- (7) Under the direction of the physician, implementation of appropriate post-injury daily treatment and rehabilitation; with the physician, determine successful completion of rehabilitation to permit safe return to activity.
- (8) Organization and administration of athletic

training program, including: (a) requisition and storage of necessary supplies and equipment; (b) supervision of training room and enforcement of policies, (c) arranging pre-season physical examinations, and (d) obtaining and maintaining medical history information for all athletes, maintaining current and accurate medical records, documenting occurrence, nature, severity, duration, treatment, recommendations and referrals, for each athletic injury.

- (9) Supervision and instruction of student trainers.
- (10) Availability for assistance when injuries occur in the physical education and intramural programs. Complement the duties of the school nurse and serve as a health educator.

## Discussion

Title IX of the Elementary and Secondary Education Act of 1973 instantly doubled the potential number of athletes engaged in interscholastic programs. In 1978-79, over 6.4 million high school boys and girls participated in interscholastic athletics.<sup>6</sup> Approximately 850,000 injuries are sustained by high school athletes yearly, with the majority of these occurring in practice when a physician is rarely, if ever, present.<sup>7</sup>

Few states have any certification requirements for coaches regarding educational preparation in injury care. Even those coaches who possess a physical education background (not mandatory), have had only minimal exposure to instruction in first aid, CPR, conditioning, and injury prevention and management. Additionally, attention to demanding coaching responsibilities precludes devotion of full attention to prevention, management, and rehabilitation of injuries.

Clearly, the need for an individual whose primary responsibility is the health supervision of the athlete is critical. The certified trainer, with a sound educational and practical background, can now provide the missing ingredient in health care continuity—immediate, on-site responsibility for the health and safety of the athlete.

Physicians will find that trainers approach their job with enthusiasm, concern, and a solid foundation of medical knowledge. Their first-hand observation of injury mechanisms and account of immediate signs and symptoms can be of tremendous value to the physician in making a diagnosis. The trainer can also serve as a very effective extension of the physician by implementing and reporting regularly on physician-prescribed treatment and rehabilitation.

Physicians, recognizing the value of the certified

athletic trainer, are increasingly vocal in encouraging their school systems to employ trainers and seek to establish positive working relationships with those trainers.

Some schools contend that they are financially unable to add an athletic trainer to their staff. Others, however, have re-examined priorities and re-assigned one coaching stipend per season to a qualified teacher-trainer. Increasing potential for legal liability as well as concern for the health of the student athlete have made the certified athletic trainer a necessity, not a luxury. The team approach, involving the cooperative effort of the physician, athletic trainer, coaching staff, family, and athlete, is the best way to ensure optimum safety and health care in school athletic programs.

## Conclusion

Today's certified athletic trainer can assume a vital role in the health care continuum for the athlete. Coupling a strong foundation of medical knowledge with on-site availability, the trainer provides the critical link between the physician, the athlete, and the coach.

The impact of the trainer has been minimized by the failure of many school districts and physicians to recognize potential benefits from employment of a trainer.

School boards cite already strained athletic budgets as the primary deterrent to hiring a trainer, yet ignore the fact that liability stands ever poised to deliver a critical financial blow to athletic programs judged negligent in prevention and management of athletic injuries. Unaware of the background and capability of the certified athletic trainer, many physicians fail to fully utilize his or her services, relegating their athletes to incomplete or inconsistent prevention and follow-up care. Physicians can provide the impetus for employment of certified athletic trainers by school districts and should endeavor to enhance and solidify the position of these individuals in the health care spectrum.

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## Mark Your Calendar

### ISMS Interim Meeting

November 13-14, 1982

#### Athletic Trainers

(Continued from page 43)

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**Howard Bates Noble, M.D.**, is chairman of the ISMS Committee on Sports Medicine. He is an assistant professor in orthopaedic surgery at Northwestern University Medical School. Dr. Noble is team physician for the Chicago Bulls professional basketball team and a member of the Governor's Council on Health and Fitness.

**Marianne T. Porter** is a certified athletic trainer. She has served as a coach and high school physical education instructor as well as an athletic trainer. She is a member of the National Athletic Trainers Association, the American College of Sports Medicine, and the Illinois Athletic Trainers Association.

**David C. Bachman, M.D.**, now lives in Ridgway, Colorado. He was formerly Director of the Northwestern University Medical School Center for Sports Medicine, Chairman of the Illinois Governor's Task Force on Athletic Injuries, and a member of the Governor's Council on Health and Fitness. He is author of the syndicated newspaper column, "Doctor Jock."

**Thomas H. Fagan** currently practices physical therapy in Santa Fe, New Mexico. He was formerly an athletic trainer with Purdue University, the University of West Virginia, the Philadelphia Eagles and the Chicago Sting. He is a member of the National Athletic Trainers Association and the American Physical Therapy Association. He is a graduate of the Northwestern University School of Physical Therapy.

**Richard L. Hoover** is president of a national chain of physical therapy facilities. He was formerly athletic trainer with Ball State University, Ohio State University, Northwestern University, the Chicago Fire, the Chicago Hustle and the Chicago Sting. He is a consultant to the Center for Sports Medicine of Northwestern University Medical School. He is a member of the National Athletic Trainers Association and the American Physical Therapy Association. He is a past president of the Illinois Athletic Trainers Association.

## Frank J. Jirka, Jr., M.D.

### AMA President-Elect

ISMS Past President Frank J. Jirka, Jr., M.D., was named president-elect of the American Medical Association in a landslide election during the AMA Annual Meeting on Wednesday, June 14. His term as president will commence in June, 1983.

A member of the AMA board of trustees and ISMS delegation to the AMA, Dr. Jirka is a councilor of the Chicago Medical Society and member of the Illinois State Medical Society Political Action Committee council.



The 1972 ISMS president served as chairman of the ISMS board of trustees, 1968-69 and as a member of that body, 1963-71.

He has served as both vice chairman and secretary of the AMA board of trustees, member of the executive committee and AMA secretary-treasurer.

Dr. Jirka, who received both the Silver Star and Purple Heart for meritorious service in World War II, has long been active in rehabilitation medicine. His candidacy received widespread support from every level of organized medicine.

Dr. Jirka's urological practice in Berwyn and Barrington permits him to serve as a clinical associate professor urology, Loyola University Stritch School of Medicine. He is a diplomate of the American Board of Urology and fellow of both the American College of Surgeons and International College of Surgeons.

Reprinted at right is the text of a nominating speech given before the AMA House by ISMS delegate and first district trustee John J. Ring, M.D., Mundelein. This is reprinted for the benefit of the membership.

## NOMINATING ADDRESS ON BEHALF OF DR. FRANK JIRKA

BY JOHN J. RING, M.D./Mundelein

*Mr. Speaker, Members of the House:*

It is with great pride that Illinois offers to you one of her favorite sons for the highest office this association can bestow.

It is an office which he regards with reverence and respect.

He knows that the president enunciates only those policies adopted by this House. But he also strongly feels that the presidency is a two-way conduit between the membership and the leadership.

Above all, he believes that the office of president of the American Medical Association belongs to the membership and to no one else.

He is a man with the uncanny knack of being where he is needed when he is needed.

*When his country needed him—he was there.*  
And you know the results.

*When his state medical association needed him—he was there.*  
As president and chairman he led the Illinois State Medical Society through one of its most difficult times.

*When the American Medical Association needed him—he was there.*  
In the court room, not as a spectator but as a plaintiff at the bar of justice, demanding relief from government utilization review regulations so onerous that they would have made life miserable for every practicing physician in this country.

*He won, the AMA won, we won.*

He is a leader and he is a listener.

He is a thinker and when necessary, he is a fighter.

He is a courageous defender of the cause of our profession and the patients we serve.

Mr. Speaker, I have the great personal privilege to place in nomination for the office of president-elect of the American Medical Association, the name of Dr. Frank J. Jirka, Jr., of Barrington Hills, Illinois.

Thank you.



# **Illinois Society, American Association of Medical Assistants**

## **Annual AAMA Convention Scheduled For September**

The impact of legislative issues on allied health care professionals and the behavioral approach to patient communications are two of many topics slated for the 26th annual convention of the American Association of Medical Assistants (AAMA) in Houston, September 20-24, 1982, at the Shamrock Hilton Hotel.

More than 20 educational sessions, geared to basic, intermediate and advanced skill levels, will be held during the meeting. Special subject workshops will allow medical assisting practitioners, educators and students to choose learning opportunities in particular areas of interest.

General sessions on Monday, September 20, will feature a panel of experts on legislation and a session designed to identify medical assistants' and patients' behavioral tendencies, with instruction on how to use this knowledge to facilitate patient relations.

Other topics to be addressed in workshops throughout the week include current ethical issues in medicine, management of stress, medical law, effective supervision of subordinates, and advocacy of the profession through public speaking skills.

Pre-convention workshops for educators, commencing on Sunday, September 19, will give medical assisting professionals guidance in preparing students for dealing with computer-age

medical offices, as well as practical information on electronic learning aids and approaches to student evaluation.

Among the faculty for the various sessions will be medical assisting practitioners and educators, physicians and other medical personnel from the University of Texas Medical Center and its sister medical institutions, and experts from related allied health disciplines.

Full details on registering for the meeting are available from AAMA's Executive Office: AAMA, One East Wacker Drive, Suite 2110, Chicago, Illinois 60601, 312-944-2722.

The American Association of Medical Assistants is a professional organization composed of receptionists, clinical assistants, secretaries, technicians, office managers and other allied health specialists who work in physicians' offices and other medical facilities. These versatile professionals are known as medical assistants, and 17,000 of them are members of AAMA in 48 societies and 600 chapters nationwide.

Information about Illinois Society, AAMA, may be obtained from Janet Binkowski, RN, president, 428 Adams Street, Dolton, IL 60419 or Ruby Jackson, CMA 7337 South Shore Dr. #625, Chicago IL 60649, chairman, Public Relations Committee. ◀

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**Pregnancy and Lactation:** Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

**PRECAUTIONS** — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

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## EKG

(Continued from page 23)

**Answers: 1. C 2. E**

The twelve lead ECG shows sinus rhythm throughout the recording with normal PR and QRS intervals and a rate of 83 beats/minute. ST segment elevation or a current of injury is present in leads I, AVL, and V<sub>1</sub> through V<sub>6</sub>. The greatest currents of injury are seen in leads V<sub>2</sub>-V<sub>4</sub> and QS patterns are in leads V<sub>1</sub> through V<sub>4</sub>. This is an acute anteroseptal myocardial infarction.

All of the answers in question two are true. The autonomic nervous system is disturbed after an infarction and it may play a role in the genesis of arrhythmia. One component usually predominates. In anterior wall infarctions, an excess of sympathetic activity can result in hypertension. In inferior wall infarctions, an excess of parasympathetic tone can cause bradyarrhythmias. Since the patient's prognosis is strongly associated with left ventricular function, much effort is directed toward myocardial preservation in the setting of acute infarction. The CPK enzyme has been used as an index of myocardial necrosis. The accuracy of this technique is partly related to frequent CPK blood samples. Analysis of CPK isoenzyme MB is specific for the myocardium.

Recently a QRS scoring system has been reported to size anterior wall infarction. This weighs Q waves and diminished R waves (R. E. Ideker *et al. American Journal of Cardiology* 49:1604 1982, May). Our patient scored 5, which was approximately 20% left ventricle infarcted. This is an interesting idea. Propranolol would be a good choice here because it could lower blood pressure and perhaps salvage some jeopardized myocardium. A catheter to accurately measure pulmonary artery diastolic or wedge pressure could guide the use of beta adrenergic blockade. Our patient had an uncomplicated course. ◀

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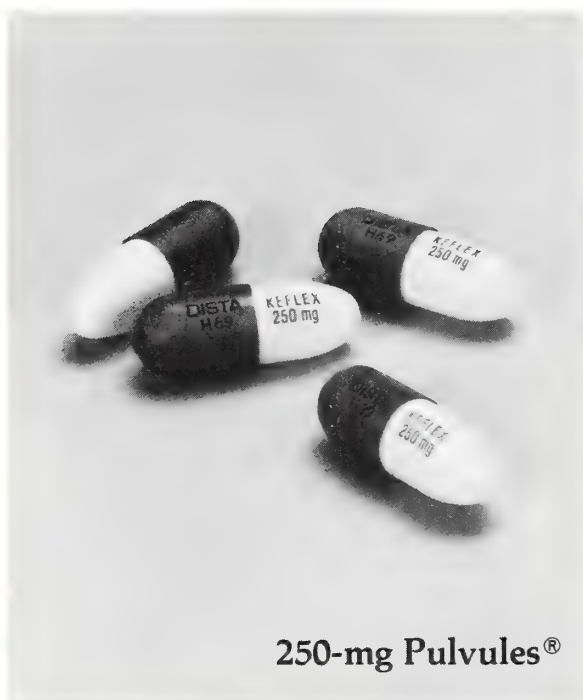
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Viewbox

(Continued from page 11)

DIAGNOSIS: Non-Hodgkin Lymphoma

- Patient 1: There are thickened folds plus narrowing and the distal esophagus is invaded.
- Patient 2: There are thickened lobulated folds in the distal one-half of the stomach.
- Patient 3: There are thickened folds plus an elliptical ulcerated (arrow) mass.

Non-Hodgkin lymphoma is a major health problem in the United States with an estimated 23,000 new cases per year. Further, it is the second leading neoplastic disease in young adult males and fourth in females (age 15-54 years).<sup>1</sup> These statistics, along with the increasing survival rates of patients with non-Hodgkin lymphoma, make early diagnosis and accurate staging especially important.

Gastrointestinal Non-Hodgkin Lymphoma

Non-Hodgkin lymphoma originates from a non-lymph node source in 40% of patients.<sup>2</sup> The GI tract, which was lymphoid tissue within the lamina propria throughout its extent, is the most common site of primary extra-lymph node disease.

The stomach is the number one site in the GI tract for development of primary gastrointestinal lymphoma (60-73%). The second most common site is the small intestine (14-22%) followed by the colon (13-15%) which includes a small percentage of appendicial lymphomas.<sup>3-8</sup>

Lymphoma occurring in children has different features than in adults. The GI lymphomas occur predominantly in boys. They are almost all located in the ileal and ileocecal regions. Histologically, however, diffuse histiocytic lymphoma predominates as in the adult.<sup>7</sup>

It may be difficult to determine if involvement of the GI tract by lymphoma is a primary process or the result of generalized spread of disease originating outside the GI tract. Most authors define primary GI lymphoma with a set of criteria similar to one originated by Dawson, *et al.*<sup>9</sup>

- (1) No palpable lymphadenopathy on initial

examination.

- (2) Normal chest radiograph.
- (3) Normal white blood cell count and differential.
- (4) Bowel lesion with only regional lymph-nodes involved at laparotomy.
- (5) Normal liver and spleen.

Using these criteria, Naqvi<sup>10</sup> estimated that 10-20% of all non-Hodgkin lymphoma originates in the GI tract.

Classification

The histologic classification of non-Hodgkin lymphoma is in a period of transition. Classification by immune markers ("T," "B," "null cells," etc.), the "Lukes & Collins" system, and other allied classification methods represent a potentially significant reappraisal of these neoplasms. The Rappaport system, which is based on the architectural patterns (nodular vs. diffuse) and cytology (histiocytic, lymphocytic—poor and well differentiated) is, however, still the predominant classification method.

The histology of primary non-Hodgkin lymphoma of the GI tract is the diffuse histiocytic type in almost 2/3 of patients. In all series the nodular architecture pattern is rare. Hodgkin disease involving the gastrointestinal tract primarily is extremely rare.<sup>8</sup>

Staging

The staging scheme for non-Hodgkin lymphoma which primarily involves the GI tract is a slight modification of the Ann Arbor staging system used for nodular lymphoma. The subscript "E" is used to designate "extra-nodal."<sup>11</sup>

TABLE I NON-HODGKIN LYMPHOMA STAGING	
IE	A single extranodal site
II <sub>E</sub>	An extranodal site plus lymph node involvement on the same side of the diaphragm.
III <sub>E</sub>	Extranodal site and nodes on both sides of the diaphragm.
IV <sub>E</sub>	Diffuse involvement of extralymphatic areas with or without nodal involvement.

A recent modification divides Stages II<sub>E</sub> into II<sub>1E</sub>-involvement of regional lymph nodes only, and II<sub>2E</sub>-involvement of non contiguous lymph



nodes. This division appears to be of prognostic value.

### Predisposing Conditions

There are several conditions which predispose to the development of gastrointestinal lymphoma. These include celiac disease and leukemia and lymphoma following treatment. The development of primary gastrointestinal lymphoma in patients with adult celiac sprue is well documented. Harris, *et al.*<sup>12</sup> analyzed 202 cases of adult celiac sprue and found 14 patients who developed lymphoma of the small bowel. Control of the celiac disease did not seem to be an important factor as 11 of the 14 cases occurred in asymptomatic patients on gluten free diets. Duration of the celiac disease, however, did seem significant as the mean interval of time from onset of the celiac disease to the development of lymphoma was 28 years.

Another predisposing factor to the development of non-Hodgkin lymphoma is previously treated Hodgkin disease. There is a 15% incidence of lymphoma in patients surviving ten years after radiation and chemotherapy. Non-Hodgkin lymphoma following treatment of acute myelocytic leukemia is also well documented.<sup>6</sup>

Lymphoma of the GI tract has been reported in patients with Crohn disease and ulcerative colitis but the significance of the association is unknown.<sup>13,14</sup>

### Clinical

The clinical presentation of patients is variable and rarely specific. A majority have chronic symptoms but patients may also present as surgical emergencies. Pain and weight loss are the most common presenting complaints, regardless of the site of the tumor.<sup>3-8</sup> Patients typically have symptoms for several months before consulting a physician. Less often there is anorexia or a palpable abdominal mass. Intussusception is common with ileocecal lymphoma and is a more specific presentation.

Malabsorption unresponsive to a gluten free diet is a fairly characteristic clinical presentation of diffuse primary "Mediterranean" intestinal lymphoma, especially if it occurs in patients with appropriate ethnic backgrounds.

In one series comprised of an unselected, non-referred patient population with gastrointestinal lymphoma, 40% of the patients presented as surgical emergencies. These patients presented with profuse GI bleeding, perforation or obstruction. Acute surgical emergencies can be an overlooked manifestation of lymphoma among physicians primarily involved with a selected, referred population.<sup>15</sup>

### Radiology

Radiology plays an important role in the diagnosis of gastrointestinal tract lymphomas. The upper gastrointestinal examination, small bowel series, and barium enema remain the principle methods of evaluating patients with primary (and secondary) disease. These barium studies are sensitive to changes due to primary lymphoma. In one series, 93% of the barium studies showed abnormalities.<sup>5</sup> The specificity of the examinations is much lower. In one series<sup>8</sup> the overall accuracy of diagnosing primary gastrointestinal lymphoma was 41%. The gastric lesions were diagnosed correctly in 71% while accurate diagnosis of small bowel lymphomas was made in only 25%. It is noteworthy that in none of these cases was the pre-investigation clinical diagnosis correct.

Although lymphoma comprises only 5% of all gastric malignancies, the stomach is the most common site of primary gastrointestinal tract lymphoma. Radiology plays an especially important role in evaluating the stomach because endoscopy and gastric cytological sampling are not accurate.<sup>16</sup> This inaccuracy is probably due to the fact that lymphomas characteristically involve the submucosal layer of bowel.

A key pathological finding helps explain some of the radiologic changes seen in gastric as well as other primary gastrointestinal lymphomas. Non-Hodgkin lymphomas do not usually incite a significant desmoplastic response. As a result, peristalsis passes through the involved area of bowel at fluoroscopy. These lesions can become quite large without causing obstruction and there is a comparatively high incidence of ulceration and perforation.<sup>16,17</sup>

### Stomach

The radiologic appearance of gastric lymphomas has been subdivided into five categories:<sup>16</sup>

- (1) *Intraluminal*, fungating mass. This is the most common appearance. There is usually a large solitary mass which often has multiple ulcerations. There is continuing peristalsis through the area of the lesion.
- (2) *Polypoid* form—these lesions can be single or multiple. They have smoothly demarcated margins and can thus mimic an intramural, extramucosal mass. These polypoid lesions can, however, have a central ulcer.
- (3) *Ulcerated* form—Single or multiple ulcers can be the principle radiographic presentation of lymphoma. The ulcers may occur in a smoothly rounded filling defect re-

sulting in the characteristic "bull's-eye" appearance (Fig. 3).

- (4) *Infiltrating form*—There is narrowing of the stomach with some rigidity of the involved area. This may be diffuse or segmental (resulting in an annular appearance.) (Fig. 1.) There can be associated areas of ulceration.
- (5) *Diffuse enlargement of the gastric folds*. In one study enlarged folds represented the principle finding in 10% of patients (Fig. 2).
- (6) Combination of types 1-5.

Tumor extension into the esophagus occurs in approximately 10% of patients (Figure 1) and transpyloric extension occurs in 33% of cases. Transpyloric extension, once thought to be diagnostic in differentiating lymphoma and adenocarcinoma, is no longer considered so, as 5% of the adenocarcinomas also extend across the pylorus.<sup>18</sup>

The radiographic differential diagnosis of gastric lymphoma is large. Adenocarcinoma, benign peptic ulcer, metastatic carcinoma, (especially melanoma, when a "bull's-eye" appearance occurs) Menetrier disease and hypertrophic gastritis are among the more common entities which may mimic lymphoma of the stomach.

Computed tomography may add to the information gained from barium studies or endoscopy. Computed tomography is especially useful in evaluating the stomach for lymphoma because lymphomas primarily involve the submucosal layer and spread laterally in the submucosa. This can easily be detected by C.T. as thickening of the gastric wall. In the series described by Buy<sup>17</sup> all patients had gastric wall thickness of greater than 1cm and the average wall was 4cm thick. In addition, enlarged regional lymph nodes can be identified.

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## Faculty Member Family Practice Program

The Black Hawk Area Medical Education Foundation is recruiting a Board Certified Family Physician to join its Family Practice Residency Program in Waterloo, Iowa. The program is community-based, affiliated with the University of Iowa College of Medicine, and part of the Iowa Network of Family Practice Residency Programs. The Waterloo metropolitan area has 125,000 people, four hospitals, and is well represented in the medical specialties.

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Let us contemplate our forefathers, and posterity, and resolve to maintain the rights bequeathed to us from the former, for the sake of the latter. The necessity of the times, more than ever, calls for our utmost circumspection, deliberation, fortitude and perseverance. Let us remember that "if we suffer tamely a lawless attack upon our liberty, we encourage it, and involve others in our doom." It is a very serious consideration . . . that millions yet unborn may be the miserable sharers of the event.

Speech [1771]

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**MONEY MANAGEMENT PRESENTATION**—Thinking of entering a private practice and looking for some suggestions? Medical students, residents and physicians can rent or purchase a 27 minute color videotape, "Borrowing Money: What a Doctor Needs to Know." This is the first in a series of practice management videotapes produced by the AMA.

The tapes are available for rental at \$25 for members (\$35 for non-members) or purchase for \$250 by sending a check or purchase order with the type of format desired to: Dept. of Practice Management, AMA Headquarters, 535 N. Dearborn, Chicago, IL 60610.

**MOTOR VEHICLE SAFETY**—The ISMS House of Delegates adopted two resolutions encouraging member involvement in efforts to support motor vehicle safety. Through a resolution entitled Motorcycle Helmet Use—28 (A-82), the House asked that physicians encourage their patients who use motorcycles to wear a protective helmet. (Currently there is no law requiring the use of motorcycle helmets in the state of Illinois. It has been shown that such usage has decreased mortality and serious injury incurred from motorcycle accidents.)

Another preventative measure was addressed by the House through a resolution entitled Seat Belt Use—29 (A-82). Supporting data showed that automobile accidents are the leading cause of death for men and women under age 35 and that four million injuries and over 56,000 deaths occur each year due to automobile accidents. The House urged that physicians support seatbelt usage.

**BURN THERAPY WORKSHOP**—"Comprehensive Care of the Burn Patient" will be the subject of a regional burn seminar, September 20-21 in Kansas City.

The two-day seminar, designed for physicians and other medical professionals from the central United States, offers workshops on evaluation, resuscitation, transfer and rehabilitation of thermally injured patients. Panel discussions will also be on the agenda at this seminar, which offers continuing medical education credit of Category 1, 24 hours.

For registration information contact: American Burn Association, Robert Gillespie, M.D., 770 North Cotner Boulevard, #215, Lincoln, NE 68505 or call 402-467-5454.

**NEW STATISTICS**—The National Center for Health Statistics has completed a study finding that American life expectancy now exceeds 73 years, at an average 69.5 years for men and 77 years for women. The over-65 population rose from 20 to 25 million during the last decade, and is expected to reach 35 million before the close of the century. Infant mortality has continued to decrease, but black infants still die at a rate twice that of white infants. Expenditures for health care more than tripled during the 70's, and are estimated to be about \$1067 per person. Copies of the report, "Health United States," can be obtained by telephoning the NCHS at 202-436-8500.

**NEWS ACCURACY**—Any individual or organization can send complaints regarding inaccuracy or unfairness in a news report to the National News Council. News organizations may also send complaints concerning restricted access of information of public interest, preservation of free communication, and advancement of accurate and fair reporting.

Write your complaint to the news organization and send a copy to the council. Be sure to include a copy of the news report, name of the publication, station or network, and the date of issue or airing. Include specific information and mail complaints to the National News Council, One Lincoln Plaza, New York, N.Y. 10023.



**PHYSICIANS IN THE NEWS**—**Frank J. Jirka, Jr., M.D.**, Barrington, was named president-elect of the American Medical Association during the June AMA Annual Meeting. (Related story on page 44). **G. Richard Locke, M.D.**, Decatur, will be awarded fellowship in the American College of Radiology (ACR) at the ACR annual meeting in September.

Election results at the Illinois Academy of Family Physicians' 34th Annual meeting include: **John Meyenberg, M.D.**, Chicago, president; **Mack W. Hollowell, M.D.**, Charleston, president-elect; **Robert T. Swastek, M.D.**, Chicago, vice president; **Joe W. Cannon, M.D.**, Lacon, re-elected speaker of the Congress of Delegates; **Hobart Don Blair II, M.D.**, Tremont, chairman of the board; and three new directors, **Stanwood S. Frank, M.D.**, Walnut, **Thomas E. Pollard, M.D.**, Danville and **Theodore E. Schafer, M.D.**, Olympia Fields. **Paul M. Schmidt, M.D.**, Galva, was named the national delegate to the AAFP and **E. Chester Bone, M.D.**, Jacksonville, was elected national alternate delegate.

**NEUROPSYCHIATRIC MEETING**—The Central Neuropsychiatric Association will hold its 60th Annual Meeting at the Drake Hotel, October 14-17. The theme of the Meeting is "Multi-Facets of Aging."

**EMERGENCY CARE SLIDE SHOW**—A slide presentation featuring advancements in emergency medical care techniques is now available from the American Academy of Orthopaedic Surgeons.

The program has two sequences—one correlating chapters of the AAOS third edition of **EMERGENCY CARE AND TRANSPORTATION OF THE SICK AND INJURED**; the second is for use with the U.S. Dept. of Transportation (DOT) EMT training course.

In addition to the slide show (priced at \$350) and textbook, AAOS offers video cassettes on Emergency Care. For more information write: Marketing Dept., American Academy of Orthopaedic Surgeons, 444 N. Michigan Ave., Chicago, IL 60611.

**JAMA REPORT ON REYE'S SYNDROME**—Data from two Michigan studies (on which warnings from the Center for Disease Control and the National Institutes of Health were partially based) recently appeared in the Journal of the American Medical Association. Children who were stricken with Reye's Syndrome were found more likely to have received medication containing aspirin during initial infection than children who did not develop Reye's Syndrome after suffering flu-like symptoms, the report stated.

Although the correlation between aspirin and the development of Reye's Syndrome is yet to be certified, evidence thus far supports the need for preventative measures.

Recent CDC warnings suggest that the risk of developing Reye's Syndrome may increase if aspirin is taken by children with chickenpox or influenza-like illnesses.

**WOMEN IN MEDICINE**—The AMA Committee on Women Physicians in Organized Medicine recently reported that the increasing enrollment of women in medical schools could raise the national percentage of women physicians to 33% within the decade. Currently the District of Columbia has the highest proportion of women physicians at 18.4%. New York is in second place with 16.7% and Illinois is among four other states with over 14%.

**USP DI**—The next edition of U.S. Pharmacopoeia-Dispensing Information is now available. This edition, labeled "1983," will supercede the 1981 edition. There will be two volumes, one with information for the physician and a second entitled **ADVICE FOR THE PATIENT**. Over 100 additional drug product monographs have been added to the data base, including vitamins, antacids, OTC drugs and newly marketed drugs. The price for the two volumes of the 1983 edition is \$37.95. It may be ordered by sending checks made payable to USP DI, 12601 Twinbrook Parkway, Rockville, MD 20852.



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# Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510, Chicago, IL 60603, (312) 236-6110.

*Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.*

## AUGUST

### Electromyography

#### Electromyography and Clinical Neurophysiology

**For:** MD's. Course, August 3-6, Chicago. **Speaker:** Ian MacLean, MD. **Sponsor:** Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago 60611. **Fee:** \$175-250. **Reg. limit:** 36. **Credit:** Category 1, 26 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

### Emergency Medicine

#### Specialty Review in Emergency Medicine

**For:** Emergency Medicine Physicians. Lecture, August 2 (5½ days), Chicago. **Speaker:** James Mathews IV, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$425. **Reg. limit:** 175. **Credit:** Category 1, 45 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Internal Medicine

#### Specialty Review in Hematology

**For:** Hematologists, Oncologists, Internists. Lecture, August 30 (5 days), Chicago. **Speaker:** William Donnelly, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 175. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Internal Medicine

#### Specialty Review in Infectious Disease

**For:** Internists, Infectious Disease Specialists. Lecture, August 30 (5 days), Chicago. **Speaker:** Stuart Levin, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 175. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Internal Medicine

#### Specialty Review in Pulmonary Disease

**For:** Pulmonary Specialists, Internists. Lecture, August 30 (5 days), Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 175. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Medicine

#### Specialty Review Course in Internal Medicine/Certifying

**For:** Internists, Medical Subspecialists. Lecture, August 1 (6½ days), Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 600. **Credit:** Category 1, 72 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Orthopedics

#### Specialty Review in Orthopedics

**For:** Orthopedic Surgeons. Lecture, August 15 (7 days), Chicago. **Speakers:** Peter Altner, MD; James Callahan, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 175. **Credit:** Category 1, 68 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Surgery

#### Fiberoptic Colonoscopy

**For:** Surgeons, Internists, Gastroenterologists. Lecture, August 25 (2½ days), Chicago. **Speaker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

#### Fiberoptic & Esophagogastric Endoscopy

**For:** Surgeons, Internists, Gastroenterologists. Lecture, August 30 (2½ days), Chicago. **Speaker:** C. Thomas Bombeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Surgery

#### Specialty Review in General Surgery, Part II

**For:** General & Specializing Surgeons. Lecture, August 16 (11 days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$600. **Reg. limit:** 300. **Credit:** Category 1, 99 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## SEPTEMBER

### Cardiovascular

#### Cardiology Update—Calcium Channel Blockers

**For:** MD's. Symposium, Sept. 21, 7:00 p.m., Vandalia. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Office of CME. Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 3 hours; AAFP Prescribed, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Clinical Hypnosis

#### Workshops on Clinical Hypnosis

**For:** MD's, therapists. Workshop, Sept. 23-25, Milwaukee, WI. **Sponsor:** American Society of Clinical Hypnosis, Education and Research Foundation, 2250 E. Devon Ave., #336, Des Plaines 60018. **Fee:** \$125-375. **Reg. limit:** 150. **Credit:** Category 1, 22 hours; AAFP Elective, 22 hours; APA, 22 hours; AGD, 22 hours. **Contact:** Wilma Kafitz. **Phone:** 312/297-3317.

### Dermatology

#### Specialty Review in Dermatology

**For:** Dermatologists. Lecture, Sept. 13 (5 days), Rosemont. **Speaker:** Marshall Blankenship, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Reg. limit:** 150. **Credit:** Category 1, 37 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Endocrinology

#### Integrated Approach to Diseases of the Endocrine System

**For:** MD's. Symposium, Sept. 17, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Office of CME. Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Internal Medicine

#### New Developments in Diabetes

**For:** MD's. Symposium, Sept. 23, 1:00 p.m., Red Bud. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Office of CME. Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Internal Medicine

#### Specialty Review in Nephrology

**For:** Nephrologists, Internists. Lecture, Sept. 20 (5 days), Chicago. **Speaker:** Norman Simon, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 150. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Internal Medicine

#### Specialty Review in Rheumatology

**For:** Rheumatologists, Internists. Lecture, Sept. 20 (5 days), Chicago. **Speaker:** William Arnold, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Ophthalmology

#### Retinal Diseases and the Uses of Laser

**For:** Ophthalmologists. Symposium/Workshop, Sept. 9-10, Chicago. **Speaker:** Donald Gass, MD. **Sponsor:** Dept. of Ophthalmology, U of I College of Medicine, 912 S. Wood St., Chicago 60612. **Reg. deadline:** 8/26. **Fee:** \$300, symposium and workshop; \$200, symposium only. **Credit:** Category 1. **Contact:** Sue Karieneck. **Phone:** 312/996-8025.

### Pathology

#### Specialty Review in Pathology/Clinical

**For:** Pathologists. Lecture, Sept. 28 (5 days), Chicago. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 150. **Credit:** Category 1, 41 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Pediatrics

#### Seminar in Pediatrics

**For:** Pediatricians, Primary Care Physicians. Symposium, Sept. 24-25, Madison, WI. **Sponsor:** U of WI—Extension, CME, 465 WARF, 610 Walnut St., Madison, WI 53706. **Fee:** \$140. **Reg. limit:** none. **Credit:** Category 1, 12 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

### Pharmacology

#### Therapeutic Drug Monitoring

**For:** MD's. Symposium, Sept. 16, 3:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Office of CME. Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Pharmacology

#### Pharmacology

**For:** MD's. Symposium, Sept. 29, 6:00 p.m., Alton. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Office of CME. Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Psychiatry

#### Psychosomatic Syndrome

**For:** MD's. Symposium, Sept. 15, 1:00 p.m., Marion. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Office of CME. Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Radiology

#### New Advances in Diagnostic Radiology

**For:** MD's. Symposium, Sept. 30, 1:00 p.m., Litchfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Office of CME. Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Radiology

### Diagnostic Imaging

**For:** MD's. Symposium, Sept. 23, 1:00 p.m., Jacksonville.  
**Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** yes. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Rehabilitation

### Physical Fitness, Cardiac Rehabilitation and Obesity

**For:** MD's. Symposium, Sept. 23, 1:00 p.m., Lawrenceville.  
**Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Spinal Cord Injury

### Management of the Spinal Cord Injured Patient

**For:** MD's. Course, Sept. 13-16, Chicago. **Speaker:** Terry Carle, MD. **Sponsor:** The Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago 60611. **Fee:** \$175-250. **Credit:** Category 1, 18 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

## Surgery

### Fiberoptic Colonoscopy

**For:** Surgeons, Internists, Gastroenterologists. Lecture, Sept. 29 (2 ½ days), Chicago. **Speaker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

# OCTOBER

## Cardiology

### Cardiac Rehabilitation

**For:** FP, GP, Internist. Seminar, Oct. 15-16, Hyatt Regency, Detroit, MI. **Sponsor:** International Medical Education Corp., 64 Inverness Drive East, Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **Contact:** Doris Price. **Phone:** 800-525-8651 x 123.

## Cardiology

### ECG Interpretation and Arrhythmia Management

**For:** GP, FP, Internists. Seminar, Oct. 22-23, Hyatt Lincolnwood, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Drive East, Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours; ACEP, 13 hours. **Contact:** Doris Price. **Phone:** 800-525-8651 x 123.

## Geriatrics

### Mainstreaming the Aged Disabled

**For:** MD's. Course, Oct. 19-20, Chicago. **Speakers:** Henry Betts, MD; Thomas Byerts. **Sponsor:** Rehabilitation Institute of Chicago/Education and Training Center, 345 E. Superior St., Chicago. **Fee:** \$100. **Credit:** Category 1, 14 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

## Geriatrics

### Aging and Illness in Primary Care

**For:** MD's. Symposium, Oct. 14-15, Madison, WI. **Sponsor:** U of WI—Extension, CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 14 hours; AOA, 14 hours; AAFP Prescribed, applied for. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Medical Education

### Problem Based Learning in Medical Education

**For:** MD's. Course, Oct. 18-22, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Medicine

### Critical Care Symposium

**For:** MD's. Lecture, Oct. 7-10, Marriott's Lincolnshire Resort, Lincolnshire. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Reg. deadline:** 10/7. **Fee:** \$295. **Credit:** Category 1, 21 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Microbiology/Immunology

### Laboratory Diagnosis

**For:** MD's. Symposium, Oct. 7, 1:00 p.m., Lincoln. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Neurology

### Contemporary Topics in Neurology

**For:** Neurologists, Psychiatrists. Lecture, Oct. 25 (5 days), Chicago. **Speakers:** Sandra Olson, MD; Frank Rubino, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$375. **Reg. limit:** 85. **Credit:** Category 1, 42 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## OB/GYNE

### Specialty Review in OB/GYNE: Practical Aspects

**For:** Obstetricians, Gynecologists. Lecture, Oct. 11 (5 ½ days), Chicago. **Speaker:** M. LeRoy Sprang, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$425. **Reg. limit:** 300. **Credit:** Category 1, 45 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Pathology

### Specialty Review in Pathology/Anatomic

**For:** Pathologists. Lecture, Oct. 4 (6 days), Chicago. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$425. **Reg. limit:** 200. **Credit:** Category 1, 48 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Psychiatry

### Diagnostic Interview Schedule Training

**For:** Psychiatrists. Seminar, Oct. 11-15, St. Louis, MO. **Sponsor:** CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** \$400. **Reg. limit:** 20. **Credit:** Category 1, 32 ½ hours. **Contact:** Loretta Giacobello. **Phone:** 314/454-3873.

## Psychiatry

### Forensic Psychiatry

**For:** MD's. Symposium, Oct. 6, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Radiology

### Advances in Diagnostic Ultrasound

**For:** Radiologists, Sonographers. Symposium, Oct. 25-27, Madison, WI. **Sponsor:** U of WI—Extension, CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 21 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Rheumatology

### Clinical Rheumatology

**For:** MD's. Symposium, Oct. 21, 1:00 p.m., Pittsfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Stroke

### Stroke and Neurosurgical Rehabilitation

**For:** MD's. Course, Oct. 12-13, Chicago. **Speaker:** Paul Kaplan, MD. **Sponsor:** The Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago 60611. **Fee:** \$250, MD; \$175, resident. **Credit:** Category 1, 14 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

## Surgery

### Specialty Review in General Surgery, Part I

**For:** General Surgeons. Lecture, Oct. 11 (11 days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$600. **Reg. limit:** 400. **Credit:** Category 1, 98 hours. **Contact:** Robert Baker. **Phone:** 312/733-2800.

## Surgery

### Fiberoptic Esophagogastroduodenoscopy

**For:** Surgeons, Internists, Gastroenterologists. Lecture, Oct. 4 (2 ½ days), Chicago. **Speaker:** C. Thomas Bombeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Urology

### Kidney-Testis Cancer

**For:** Urologists. Course, Oct. 7-9, Airport Sheraton, Indianapolis, IN. **Sponsor:** American Urological Assn., P. O. Box 25147, Houston, TX 77265. **Reg. deadline:** 10/7. **Fee:** \$230, members; \$260, non-members. **Reg. limit:** 150. **Credit:** Category 1, 16 hours. **Contact:** Alice Henderson. **Phone:** 713/790-6070.

## Tenth Illinois Congress on Continuing Medical Education

### "Determining What Physicians Need to Learn— Needs Identification in CME"

September 24-25, 1982  
Drake Oakbrook Hotel

This year's special anniversary program has been expanded to two full days and will include a variety of workshops on how to identify learning needs in your physician audience and how to select appropriate needs identification procedures.

Special keynote speaker will be Edmund D. Pellegrino, M.D., John Carroll University Professor of Medicine and Medical Humanities, Georgetown University Medical Center, Washington, D.C.

Full program details will be available after June 15; to receive a brochure and enrollment form, write or call . . .

Illinois Council on Continuing Medical Education  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110



TENTH ANNUAL CONGRESS/CME

## **Determining What Physicians Need to Learn—Needs Identification In Continuing Medical Education**

*September 24-25, 1982, at the Drake Oakbrook Hotel, West  
22nd St. at York Road, Oak Brook, Illinois.*

This year's Congress is the third in a four-year cycle covering the fundamentals of CME planning. The major emphasis in 1982 is on *how to identify physicians' learning needs*; the program will also include a variety of other topics that can satisfy CME concerns of physicians in Illinois and throughout the nation.

In response to demand, this year's special anniversary Congress has been extended to two full days—Friday afternoon and evening, all day Saturday—to offer you a wider choice of small group workshops and free time for informal discussion.

Highlighting this year's program will be Edmund D. Pellegrino, M.D., John Carroll University Professor of Medicine and Medical Humanities, Georgetown University Medical Center, Washington, D.C.

Among the small group workshops this year will be: Differentiating between Needs and Interests, Simulations in Needs Identification, Malpractice Data in Needs Identification, Expert Observation as Needs Identification, Interest Surveys and Audience Feedback, and Patient-Problem Inventory & Self Assessment Exams in Needs Identification.

Other workshops will include Introduction of Microcomputers, Introduction to Evaluation, and two special workshops for non-physician medical educators and administrative support staff.

For additional information, write or call the Illinois Council/CME, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603, (312) 236-6110.

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## Family Practice Physician Chicago Suburb

The Wholistic Health Center of Oak Lawn is seeking a Medical Director to head a professional team on July 1 or August 1, 1982. This is an ambulatory unit admitting to Christ Hospital, an 873 bed tertiary care and teaching hospital affiliated with Rush Medical College. The position requires a board eligible/certified Family Practice physician with an interest in a wholistic approach to patient care and a desire to teach medical students and Family Practice residents. Rush teaching appointment. Liberal salary/extensive fringe benefits/vacation/education leave.

### CONTACT

Chairman, Department of Family Practice  
Dr. Charles Range  
Christ Hospital  
Of the Evangelical Hospital Association  
4440 West 95 Street  
Oak Lawn, IL 60453  
(312)-857-5324

## "I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

August 16	Lutheran General Hospital	Park Ridge
August 23	Christ Hospital & A.C.S.	Oak Lawn
August 30	Anchor & A.C.S.	Chicago
Sept. 14	St. Francis Hosp. & A.C.S.	Blue Island
Sept. 20	Condell Memorial Hosp. & A.C.S.	Libertyville
October 4	Alexian Bros. Med. Centr.	Oak Forest
October 4	Christ Hospital & A.C.S.	Oak Lawn
October 11	Anchor & A.C.S.	Chicago
October 18	Lutheran General Hospital	Park Ridge
November 9	St. Francis Hosp. & A.C.S.	Blue Island
December 6	Christ Hospital & A.C.S.	Oak Lawn
December 6	Anchor & A.C.S.	Chicago



# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**BENTON:** Family Physician wanted to join growing medical staff associated with a modern, 113-bed community hospital in southern Illinois. Guarantee and other benefits. Excellent recreational and university facilities nearby. **CONTACT:** Ann Acton, Franklin Hospital, Benton, 62812, (618) 439-3161, Ext. 367/368. (4)

**CARBONDALE:** Family or General Practice. Community Health Center in southern Illinois, 10 miles from SIU-Carbondale. Affiliation with Black Lung Clinic Programs possible. Established practice with multi-disciplinary staff. Position available immediately. Salary, fringe benefits are very competitive; malpractice insurance and vacation also provided. **CONTACT:** George M. O'Neill, Shawnee Health Service & Development Corporation, 103 S. Washington, #210, Carbondale 62901 (618-457-3351). (4)

**CENTRAL ILLINOIS:** Two community hospitals within twenty minutes of each other are currently seeking a urologist. Possible partnership with consulting urologist now servicing this area. More patients than one urologist can handle. Area is known for recreational activities. **Contact:** Search Committee, P.O. Box 430, Pana, 62557. (217-562-2131 x271) (4)

**CLIFTON:** Service Area, 8,500—Immediate opening for family practitioner in rural setting. First year: guarantee, office space/staffing provided. Seventy miles south of Chicago on interstate highway. Excellent school system. Obstetrics or general internal medicine background helpful. **CONTACT:** George Rasmussen, Central Community Hospital, Clifton 60927. AC 815-694-2392. (10)

**FAIRBURY:** Family practice physician—Excellent opportunity to join General Practice Physician planning retirement in two years. Cross coverage is available in this thriving rural practice. Fairbury Hospital, a 112-bed JCAH accredited hospital, offers income guarantees and other financial assistance. **Contact:** Kate H. Dickey, Director, Physician Recruitment, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739. (815-692-2346 x215) (4)

**GALESBURG:** Population 35,305. Seat of Knox County, pop. 61,300. An attractive college community 180 miles from Chicago. Near Peoria, Quad-Cities. Diversified industry and agribusiness. Full selection of educational, cultural and recreational activities. For information on practice opportunities, **CONTACT:** David D. Fleming, Vice-President, Galesburg Cottage Hospital, 695 N. Kellogg St., Galesburg 61401. 309/343-8131. (4)

**GIBSON CITY:** Family Practitioner—Excellent opportunity in East Central Illinois; modern, well equipped hospital with

attached private SNF; new professional office space and incentives available; rural community within 30 minutes of major university, tertiary care center, metropolitan area with major shopping, recreational and cultural activities. **Contact:** Daniel J. Marion, Executive Vice President, Gibson Community Hospital, Gibson City 60936 (217-784-4251). (9)

**KEWANEE:** 108 bed community hospital involved in an expansion program is interested in recruiting family practitioners to our service area of 35,000 population. Several practice opportunities exist in group or solo practices. The population centers in the service area range from 15,000 in population and less. **Contact** Harold L. Bischoff, Kewanee Public Hospital, 719 Elliott Street, Kewanee 61443 (309) 853-3361. (4)

**LINCOLN:** 20 miles from Southern Illinois University School of Medicine in Springfield and halfway between St. Louis and Chicago on I55. Need two family practice physicians for growing practice. Office facilities available with 10 man medical group. **Contact** Mary Richter, 311 Eighth, Lincoln 62656. (217/732-9681). (4)

**MARSHALL:** Population 4,000. County seat of Clark County. Rural community. Comparatively new medical center with available space for 4 doctors. Presently have 2 doctors. Facility fully equipped with lab, x-ray, therapy, emergency room, pharmacy. Located 17 miles from three major hospitals. Have excellent school system and recreational facilities. **CONTACT:** Donald B. Smitley, Admin., 410 N. 2nd St., P.O. Box 219, Marshall 62441, 217-826-2358. (4)

**METROPOLIS:** 8,000 population. Openings in Family Practice. 4 physicians at present. Southern Il. on Ohio river. Complete office facilities annexed to hospital. Financial assistance. Near two large lakes and recreational area. Just completing construction and renovation. 6-bed IC-CCU and 51 MS beds. **CONTACT:** Loren L. Erwin, POB 111, Metropolis 62960 (618-524-2176). (9)

**SULLIVAN:** Population 5,000. New medical center with complete office and ancillary services available. Near universities and colleges. All recreational facilities nearby. **CONTACT:** Sandra Elder, 2 W. Adams, Sullivan 61951 (217) 728-8316 or (217) 728-4186. (4)

**WATSEKA:** Population service area 35,000. Opening for orthopedic surgeon. 23 physicians on staff at present. 85 miles from Chicago in rural area, 160 bed hospital. Within one hour drive of major universities. Very liberal financial package available first year. **Contact** Paul F. Wenz, 200 Fairman Street, Watseka 60970. (815) 432-5201. (4)

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12 insertions	33.00	44.00	77.00	110.00

## POSITIONS AND PRACTICE

**MIXED MULTI-SPECIALTY INCORPORATED GROUP**—30 miles south of Chicago seeks Family Practitioner. Life, disability, malpractice insurance and all medical dues paid. X-ray and lab in building. Excellent hospital facilities half block from office. Salary, profit sharing and pension plan \$54,000. Partnership after one year. Write or call collect, Mr. E. Karmis, 1400 Otto Blvd., Chicago Heights, Illinois 60411. Phone (312) 756-4400.

**MULTISPECIALTY GROUP** thirty miles southwest Chicago seeks young board eligible Ob-Gyn man to join eight man group. Incentive plan, profit sharing, new building. Excellent practice opportunity and schools. Contact Howard Osmus, Administrator, Hedges Clinic, Frankfort, IL 60423 (815-469-2123).

**SMALL TOWN MEDICINE/BIG CITY ADVANTAGES**—Seeking physician to join board certified active family practice group. Thriving community of 10,000, west of Chicago. Modern, well equipped, 3 physician office with full lab and X-ray facilities. 110 bed, primary care hospital 1 mile from office. Salary guarantee, malpractice coverage, other benefits. Opportunity for full partnership. Send resume and C.V. to: P.O. Box 72, Geneva, IL 60134, or call 312-232-2133.

**DOCTORS NEEDED** in Wisconsin and Minnesota, all specialties, all locations. For confidential information, mail your C.V. to Medicus, W62 N281 Washington Avenue, Cedarburg, Wisconsin 53012.

**WANTED PHYSICIAN** to share office or take over lease in Southwest Rockford seeing 20-30 patients daily. Call 815-964-0500 or 312-275-4494.

**IOWA & ILLINOIS:** Young group of Emergency Physicians serving small to medium hospitals and clinics in Iowa and Illinois seek additional physicians to complement present group. Full or part-time Emergency Medicine opportunities or combination FP/ED also available. Excellent compensation package starting at \$71,500 per year for ten 24 hour shifts per month including profit sharing, malpractice, life and disability, medical and dental, and liberal paid vacation and meeting time. Excellent specialty back-up. Send C.V. or call William Foley or Martin Sands, M.D., Box 1469, Bloomington, Illinois 61701; Phone: (309) 452-9321.

**FAMILY PRACTITIONER**—To locate in Nashville, Illinois. Excellent educational system and recreation. Financially sound community. One hour from St. Louis. JCAH 72-bed hospital in Nashville. Contact: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263, 618-327-8236.

**U.S. AIR FORCE MEDICAL CORPS** is currently accepting applications for physicians in the following specialties: Surgery (All subspecialties), Obstetrics/Gynecology, Otorhinolaryngology, Anesthesiology, Urology, Rheumatology, Neurology, Psychiatry. For further information contact: Capt. Brian Legg (312) 263-1207. Call collect or send CV to 111 N. Wabash, Suite 1805, Chicago, Illinois 60602.

**PHYSICIAN OPPORTUNITY LINE**—Openings for Board-Certified family practitioners to establish own practice in Chicago vicinity. Hospital-Based Physicians, MacNeal Memorial Hospital, 3249 S. Oak Park Ave., First year guarantee. Additional openings for physicians of all specialties. For information call 967-0042.

**OPHTHALMOLOGY—LOCUM TENENS** for a private practice in Oak Park, Ill. July 15—August 15. Call (312) 944-7478 evenings.

**HEMATOLOGIST/ONCOLOGIST & RHEUMATOLOGIST**—Mesa, Arizona. Join 9 physician IM group. Completely equipped, modern clinic located one block from 375 bed acute care hospital. Financial guarantees and excellent benefits provided. 15 miles from Phoenix—recreation unlimited with nearby lakes, mountains. Contact Phillip Kelbe at 414/785-6500.

**INTERNAL MEDICINE**—Tired of the city rat race? Come to a small town and practice with me! I have an adequate practice waiting for you. Delightful southwestern Wisconsin town. Good fishing, hunting, people. Guaranteed salary. Hospital nearby. Time to live and get reacquainted with your family. Ideal opportunity for someone who wants to slow down, but not quit. Write to: J. R. Heersma, M.D., 124 Iowa Street, Muscoda, WI 53573. Call collect evenings: 1-608-537-2774.

**INTERNIST/CARDIOLOGIST**—Multispecialty clinic in community of 20,000 just outside Peoria. 13 physicians with service population of 55,000 looking to add 2 physicians. 225 bed accredited hospital within 2 blocks. Modern facilities and equipment. Negotiable first year salary & complete benefits. Second year salary or % of billings. Excellent school system, parks, rivers, country clubs, conservation area nearby. Please call Phil Kelbe at 414/785-6500 (collect).

**ASSOCIATE DESIRED**—For July 1983-1984, family practitioner to join two family physicians, internist and surgeon in a newly formed group; situated 70 miles west of Chicago in a semi-rural area; family practice oriented hospital with full privileges; equal partnership after 24 months; salary and fringe benefits open to negotiation. Send full vitae to: Irving Frank, M.D., (Director) 954 W. State Street, Sycamore, IL 60178.

**FAMILY PRACTITIONER, PEDIATRICIAN, OB/GYN**, needed by well established small clinic in small town in northern Illinois. Beautiful country. A good place to raise a family. Office with laboratory and x-ray. 150 bed hospital. Please send resume to Box number 1046, Illinois Medical Journal, 55 East Monroe, Suite 3510, Chicago, Illinois 60603.

**OPHTHALMOLOGIST** to initially join part or full time and to ultimately take over established solo practice in a southwest suburb of Chicago. Write P.O. Box 185, Oak Lawn, Illinois 60454.

**GENERAL SURGEON.** Enjoy the security of group practice with the freedom of independent practice. If you are a board certified or board eligible general surgeon, we have an interesting opportunity for you. A general surgeon is needed immediately to form an independent practice in a very desirable Northern Wisconsin community with a drawing population of 100,000. All major specialists available for consultation. A growing community hospital with 240 beds with excellent medical and surgical subspecialty representation. Opportunities for endoscopy and peripheral vascular surgery also exist. For further information write: Administrator, P.O. Box 1646, Wausau, Wisconsin 54401.

**STUDENT HEALTH SERVICE PHYSICIAN**—join staff of 5 other MDs providing general care for 17,000 students, excellent community, 40 hour week; good fringe benefits and competitive salary, 9 to 11 month continuing contracts. Illinois license. Contact William Warren, Student Health Service, Illinois State University, Normal, Illinois 61761. 309-438-8655. Illinois State University is an equal opportunity affirmative action employer.

**OHIO—ABAI CERTIFIED**, 68 years old, tremendous practice, large city, three medical school affiliations, and Director of Hospital Allergy Clinic, seeks associate for partnership, etc. Must be ABAI Certified or eligible. Send curriculum vitae and other pertinent information to Box #1047 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**MEDICAL PLACEMENT ASSOCIATES** is recruiting in this area on behalf of clients throughout the country. Opportunities exist in: Anesthesiology, Dermatology, Family Practice, Gastroenterology, Gerontology, Gynecology, Internal Medicine, Obstetrics, Ophthalmology, Orthopaedics, Otolaryngology, Pediatrics, Radiology, and Urology. For further particulars call Steve Sell or Robert Acton (collect) at (313) 557-3350, or write: Medical Placement Associates, 18877 West 10 Mile, Southfield, MI 48075.

**CENTRAL WISCONSIN**, a 50 physician multi-specialty group has openings for physicians in the following specialties: Otolaryngology, OB/GYN, Cardiology, Neuroradiologist and General Surgery with a fellowship training in Peripheral Vascular Surgery. Competitive first year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K. L. Day, M.D., Wausau Medical Center, S. C., 2727 Plaza Drive, Wausau, WI 54401 or call collect (715) 847-3351.

**CHICAGO, ILLINOIS.** Well established medical center in high volume area needs doctor full or part-time. Some welfare; Reasonable rental; Excellent opportunity for growth. Call (312) 221-2627 or 268-4611.

## SITUATIONS WANTED

**PEDIATRICIAN:** University trained, seeks practice opportunity or salaried position in West or Northwest suburbs of Chicago—Wheaton, Glen Ellyn, Elk Grove Village, Schaumburg, Hoffman Estates, Hanover Park, Bartlett, Bloomingdale. Also will be interested in purchasing a practice. Currently involved in part time private practice with Chicago clinic. Contact Box No. # 1045, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**GENERAL SURGEON,** Board certified, also certified in board of Colon and Rectal Surgery. Wide experience in general surgery and endoscopy, seeking practice opportunity. Contact Box #1048 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL. 60603.

**PHYSICIAN WITH 10 YEARS** experience in trauma and emergency care currently 3rd year resident in Peds, wishes to relocate in southern Illinois. Seeking full-time job, solo or group practice. Call (314) 481-2948 or write c/o Box #1049, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, Ill. 60603.

**ANESTHESIOLOGIST** seeks group or hospital practice U.S. graduate Anesthesia fellowship 1981-1982. Contact Robert Nelson, M.D., 510 Marmac, Galesburg, Illinois 61401; (309) 344-1900.

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**FOR RENT** in Orland Park—Ravinia office complex. New condominium office building. 1200 square feet—5 examining rooms. Immediate occupancy. Call 312-798-3039.

**OFFICE SPACE TO SHARE** Family practitioner seeks physician to share 1200 square ft, fully furnished office in Willowbrook. Close to Hinsdale, Good Samaritan, LaGrange and Suburban Hospitals. Please call 986-1177.

**FOR LEASE:** Suite available in Professional Medical Building located in densely populated western suburb of Lisle, Illinois. Especially suitable for family practice or any other medical specialty. Respond to Box 1036, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago. IL 60603.

**FAMILY PRACTICE & OFFICE FOR SALE:** Retiring from long lucrative practice. Fully equipped and staffed office near JCAH Hospital—So. Illinois. Available July 1. Reply—physicians only—please include resume. Write Box #1043 c/o Illinois Medical Journal, 55 E. Monroe Suite 3510, Chicago IL 60603.

**MEDICAL BUILDING FOR SALE**—Highland View Medical Center, 8556 S. Ashland, Chicago; 6,000 sq. ft., brick and granite exterior. Two parking lots; 10,000 sq. ft; 50 spaces or more. General waiting room includes reception office, business office, insurance office and pharmacy. Eleven doctors' offices with five separate prep rooms. Nurses' reception area and 2 nurses' offices. Complete dental suite w/2 examining rms., lab, waiting rm. Reception area for Xray, lab, EKG. Complete XRay Dept and laboratory dept. Emergency, EKG and ultrasound room, doctors' and nurses' lounges. Heating/A.C., gas—forced air—zoned heat. Two separate units, Central Air—Heat & A.C., units in basement. Storage 1/3 basement. Write or call (312) 779-2400.

**1550 SQ. FT. OFFICE SUITE** in newly constructed professional building in Champaign, Illinois. The building is currently occupied by three separate family dental practices which provide a high volume of patients to the building. The building is in an ideal location in the respect that it is the only professional building that offers medically related services in the area. The single story facility also provides easy accessibility and parking for handicapped and elderly persons, a 50 car parking lot, convenient bus lines, and a health and fitness center for the tenants and their staff. For information, please contact Dr. Paul Stines at (217) 352-2886.

**3333 WEST PETERSON AVENUE.** Medical suite in medical-dental building. Large common waiting room. Receptionist and switchboard available. Ample parking. Accessible by public transportation. Ideal for any specialty. Call 478-8785.

**WATERTOWER PLACE**, 845 North Michigan Avenue. Sublet to ophthalmologist. Part time. Fully equipped office. Two refracting lanes. Consultation room. Waiting room. Mydriatic room. Business office. Call 951-1132.

**FOR RENT-SUBURBAN.** Professional arts building, North Aurora. Excellent practice area, 5 minutes from hospital. Medical suite 832 square feet, ample parking. Family practice or specialists. Immediate occupancy. For information call 892-3580.

**PROFESSIONAL OFFICE SPACE** for rent in South Elgin, Illinois. New building, 1300 sq. ft. Four months free rent with 5-year or longer lease. (312) 742-8009 or 742-8901.

**FOR SALE OR LEASE.** Psychiatrist's office building. Beautiful, peaceful setting adjacent to major psychiatric hospital. Far western suburbs. Suitable for one or more practitioners. Excellent terms. All replies confidential. (312) 784-0663.

**MEDICAL CENTER FOR RENT** in active Shopping Center, 2301 E. 95th St, Chicago, IL. Complete and ready to open, waiting rm, 18 exam rms, x-ray rm, 4800 sq ft, central heat & a/c. GARY SOLOMON & CO. 312/334-5400.

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## MISCELLANEOUS

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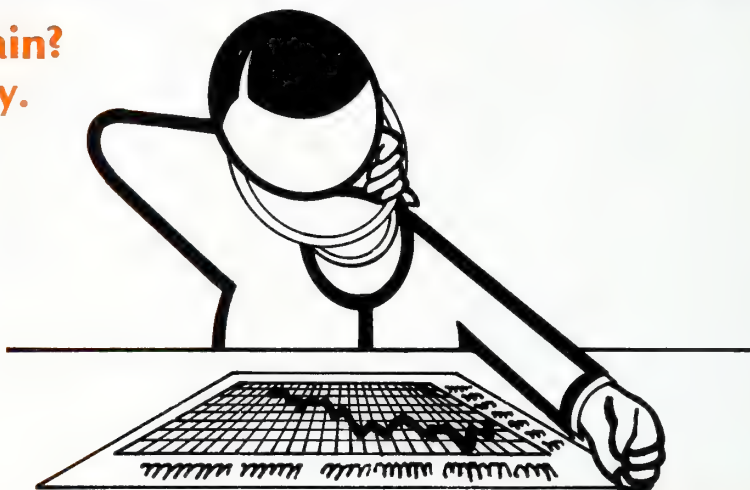
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# REPORT

## FOR *Illinois Physicians*

### Changes Made in HIA Benefit Program

Several benefit changes have been made in the Health Improvement Association's (HIA) coverage for the period beginning July 1.

Following is a report on the new HIA benefits:

- \$1,000,000 Lifetime Benefit.
- \$200 Deductible: (After two members of a family have met the annual \$200 deductible, other family members will have no deductible for the balance of the year).
- \$2,000 Annual Out-of-Pocket Expense Limitation: (After two members of a family have met the \$2,000 Out-of-Pocket expense limitation, other family members will have eligible benefits paid at 100 per cent of Usual and Customary for the balance of that calendar year).
- Eligible benefits for private duty nursing will be paid up to a maximum of \$1,000 per month.
- Eligible benefits for inpatient mental services will be paid up to \$25,000 per calendar year, with a \$50,000 lifetime maximum.
- Eligible benefits for outpatient mental services will be paid up to \$25 per visit, with a \$1,000 annual maximum and a \$10,000 lifetime maximum.
- Unmarried dependent children are covered to their 23rd birthday.
- All new members have a 270 day waiting period for pre-existing conditions.

BENEFIT	\$200 Deductible Applies	Payment Level	\$2,000 Out-of-Pocket Limit Applies
• Medically Necessary In-Patient Hospital Services . . .	No	80%	Yes
• Out-Patient Hospital Services . . . . .	Yes	80%	Yes
• Physicians Services . . . . .	Yes	80%	Yes
• Prescription Drugs . . . . .	Yes	80%	Yes
• Ambulance . . . . .	Yes	80%	Yes
• X-Ray and Laboratory . . . . .	Yes	80%	Yes
• Radiation Therapy . . . . .	Yes	80%	Yes
• Chemotherapy . . . . .	Yes	80%	Yes
• Renal Dialysis Treatments . . . . .	Hospital-No Physician-Yes	80%	Yes
• Physical Therapy . . . . .	Yes	80%	Yes
• Maternity Care . . . . .	Hospital-No Physician-Yes	80%	Yes
• Allergy Shots . . . . .	Yes	80%	Yes
• Human Organ Transplants . . . . .	Yes	80%	Yes
• Shock Therapy . . . . .	Yes	80%	Yes
• In-Patient Care in Plan-Approved Skilled Nursing Facilities . . . . .	Yes	80%	Yes



# Benefits Explained For Emergency Care

(Please Note: Blue Cross and Blue Shield of Illinois has developed a booklet for its membership explaining the proper use of emergency benefits provided by the Plan. Because the infor-

mation contained in the booklet may be of interest to you, we are including excerpts from it in the following report.)

"Blue Cross and Blue Shield benefits cover the treatment of injuries resulting from accidents, attacks on your person, slips or falls—in brief, any injury which requires prompt attention. These include...fractures of all types, sprains or strains, burns, cuts and any injury requiring immediate surgery.

## **Follow-ups not covered**

"Benefits include Out-Patient or Emergency Department care and the services of the attending physician, provided treatment is received within 72 hours of the accident or injury. This applies only to the first treatment. Follow-up out-patient visits are not covered under emergency benefits. In those cases where a hospital stay is necessary, you will be covered for all charges eligible under your particular Blue Cross and Blue Shield program.

"Since accidents can occur anywhere at any time, it's good to know that your Blue Cross and Blue Shield membership card quickly identifies you to hospitals and doctors throughout the country. Always carry it with you when you travel.

"Benefits are provided for medical emergencies when symptoms are severe enough to endanger life or bodily functions unless the patient receives prompt treatment. The following conditions are examples of true medical emergencies...sudden chest and arm pains severe enough to indicate a possible heart attack, severe bleeding of any kind, including vomiting of blood, sudden inability to move arms or legs, severe allergic reactions and attacks or dizziness severe enough to cause staggering.

## **First treatment eligible**

"In cases such as those listed above...benefits are provided for the first treatment whether received in the Emergency Department or Out-Patient Department of a hospital or clinic, or in the doctor's office. Treatment should be received immediately for symptoms severe enough to require emergency care. As is the case with injuries, only the first treatment is eligible for emergency benefits. If a hospital stay should be necessary after your condition is diagnosed, you will, of course, be covered for all services eligible under your particular Blue Cross and Blue Shield program."

## CPT-4 Codes Should Be Used for Radiology Claims

The following CPT-4 codes should be used when reporting radiology procedures on your Blue Shield claim forms (PSRs).

The injection of contrast media and the placement of the needle, or catheter, is regarded as a surgical procedure and should be billed independently of the interpretation or the results.

The appropriate CPT-4 procedure codes for most invasive services may be located in the #30000 series under the Cardio-Vascular section of the CPT-4 procedure code book. Radiologists should not bill Blue Shield using CPT-4 procedure code book. Radiologists should not bill Blue Shield using CPT-4 codes that are described as "completed procedures," because it will delay claims or result in an improper payment.

## Rockford Office Handling Some HIA Processing

Claims for certain HIA members who are under 65 years of age are now being processed by the Rockford District Office and should be mailed directly to the office.

Among the groups being handled by the Rockford Office for services incurred after July 1, are: Individual Groups #12000-120099 (HIA \$200 Deductible Program); and Employer Groups #182000-182099 (\$100 Deductible Plan), #182200-182299 (\$250 Deductible Plan), and #182500-182599 (\$500 Deductible Plan).

Claims for these groups should be sent to:

**Health Care Service Corporation**

**Rockford District Office**

**Post Office Box 418**

**Rockford, Illinois 61105**

Claims for members aged 65 and over with #2000-20099 should be sent to the Chicago Office at 233 North Michigan Avenue, Chicago, Illinois 60601.

# Medicaid-Medicare-Champus Report

## IDPA to Conduct New Series of MMIS Seminars

At the urging of ISMS, IDPA has agreed to conduct another series of educational seminars on how to complete the MMIS claim form. The second round of IDPA's MMIS seminars began on June 21, 1982 in several counties outside of Cook County. IDPA had conducted a series of MMIS seminars in the Chicago area during April 1982.

IDPA intends to implement its downstate MMIS programs in three phases. Phase I, which began on June 21, covered cities in central Illinois, Phase II will be conducted in southern Illinois and is tentatively scheduled to begin during late July and Phase III will cover cities in northern Illinois, with the exception of Cook County, beginning in mid-August.

Once the specific times and locations for these seminars are confirmed, IDPA will forward notices to all physicians who currently participate in the Medical Assistance Program. The ISMS Division of Professional Relations recently co-sponsored MMIS workshops with county medical societies around the State. The ISMS/county medical society programs sought to clarify many of the confusing aspects of MMIS. These programs were well attended by physicians and their staff. ISMS will continue to closely monitor the MMIS program and will provide physicians with periodic updates about the program in *Action Report* and the *Illinois Medical Journal*. In addition, physicians should not hesitate to contact their ISMS Field Representative for clarification of IDPA's policies on MMIS. Physicians in Cook County should contact Christine Szuflita at the CMS headquarters, (312-670-2550) with routine MMIS inquiries.

Recently, physicians received a notification from IDPA which outlined the basic health protection plan for certain categories of IDPA recipients. This basic health coverage became effective July 1, 1982. The plan applies *only* to the following categories: AFDC-Adults receiving Medical Assistance No Grant (AFDC-MANG Adults) and all recipients eligible under General Assistance (GA) and Aid to the Medically Indigent (AMI). All other categories of eligible recipients will continue to receive the full IDPA benefit package.

ISMS staff has received several calls from ophthalmologists and psychiatrists regarding exclusion of these specialties from this health protection plan. Subsequent to negotiations with IDPA, the Department will cover *all* physician services regardless of specialty. There are several exceptions for GA and AMI recipients. GA and AMI recipients have never been eligible for psychiatric and physical rehabilitation services. Home Health Agency visits *are* covered for AFDC-MANG Adults, but not for GA and AMI categories. Also, optical services, for manufacturing and dispensing of eyeglasses are not covered for GA, AMI and AFDC-MANG adults. However, the medical services of an ophthalmologist will be reimbursed by IDPA.

The Department is attempting to limit the utilization of emergency room services by recipients to those services that are deemed to be "true" emergencies.

The emergency room physician will make the determination as to whether or not the visit is a "true" emergency. IDPA is attempting to eliminate the unnecessary utilization of emergency room services by recipients. IDPA will reimburse hospitals and physicians for emergency services rendered. The department will distribute educational information to recipients on the proper use of the emergency room. Physicians who provide office services from a hospital outpatient department are considered to have provided a medical office visit. These services should be billed to IDPA identifying the place of service as the physician's office. The IDPA policy on billing outpatient services was reviewed in a previous Medicaid/Medicare report. ISMS staff will continue to monitor IDPA's implementation of this basic health protection plan.



**Six Month Rule:** In addition, IDPA will reinstitute its six month timely submittal rule for physician claims for services rendered subsequent to June 30, 1982. Claims for dates of service prior to June 30 are not subject to the six month timely submittal rule. At the request of ISMS, IDPA waived the timely submittal requirements for approximately one year. The ISMS request was granted by IDPA so as to not penalize physicians whose claims were suspended in the MMIS claim backlog or penalize those physicians who were not promptly re-enrolled as providers of medical service under MMIS.

Beginning July 1, 1982 office managers should develop a "tickler" file indicating the date IDPA claims are originally submitted. Physicians should carefully review all subsequent Remittance Advice Sheets to ensure that their claims are being accepted into the claim processing cycle. The Remittance Advice Sheets indicating that a physician's claim was rejected or suspended within six months of the original date of service will serve as a proof of compliance with the timely submittal rule. Additionally, any correspondence between the physician and another third party payer, the local Public Aid office or the patient, in an attempt to obtain payment or establish recipient eligibility, will serve as proof of compliance with this ruling. ISMS staff suggests that any correspondence with either IDPA claim processing unit in Springfield or the local Public Aid office be properly dated and forwarded by certified mail in order to fully document timely compliance.

**Pre-MMIS Claims:** The Illinois Department of Public Aid has indicated that it will close out the system used for processing physician claims prior to the implementation of MMIS. The Department has targeted September 30, 1982 as the cut-off date for receiving new or resubmitted DPA 132 claim forms (pre-MMIS claims). This deadline will affect only those physician claims for services rendered prior to the MMIS implementation date. IDPA has also indicated that it will continue to process those DPA 132's that have been submitted to IDPA by the deadline until its "in house" inventory has been eliminated. The Department will issue a notice to physicians who participate in the medical assistance program which will outline the specific details of how IDPA will close out the claim processing cycle for pre-MMIS claims. At the request of ISMS, IDPA has established a toll free "hot line" to answer physician inquiries on their unpaid pre-MMIS claims. This number is (800) 252-8936.

**Medicare:** Effective July 1, 1982, all Medicare Part B carriers will upgrade each physician's customary and area prevailing profiles based upon charges submitted on Medicare Part B claims during calendar year 1981.

A physician's customary profile is only one of three factors used to determine the Medicare allowable charge. Medicare also considers the area prevailing charge and the actual amount billed to Medicare by a physician. The Medicare carriers will reimburse the lowest of these three amounts at 80% of the Medicare determined allowable charge.

It should be noted that increases to the area prevailing fee profile are limited by the economic index factor established by the federal government. The economic index limits the increase to a specific percent above the prevailing charges established in 1973. The percent of increase for Fiscal Screen Year 1983 is 8.88%.

Physicians may obtain their individual customary and area prevailing profile for their specialty directly from EDS Federal Corporation, the Medicare Part B carrier for Illinois. These requests must be in writing and sent to: EDS Federal Corporation, 999 E. Touhy - Suite 500, Des Plaines, IL 60018, Attn: Freedom of Information Request.

Finally, a clarification to last month's report on Medicare. It was reported that claims for hospital visits for the acute conditions of renal failure, myocardial infarction, cerebrovascular accident and metastatic carcinoma may be submitted in excess of 24 days without supporting documentation. Physician claims for these diagnoses will require supporting documentation if the hospital length of stay exceeds 31 days. Acceptable documentation would include a notation on the claim or on the hospital discharge summary of an additional diagnosis which required a longer period of hospitalization, complications resulting from a surgical or medical treatment plan, that the patient was admitted to ICU or CCU and/or the patient received CPR during the period of hospitalization. EDS-F requests that the date of the complicating factors also be noted on the HCFA-1490 claim form.

# President's Page

## Professional Liability Insurance



Professional liability insurance was first sponsored by ISMS in 1969, when filing of medical malpractice suits began to accelerate. At that time, it was expected to be no more volatile than other types of ISMS-sponsored programs for health, disability or accident/life insurance.

Only six years later, the company then underwriting the ISMS-sponsored professional liability program increased its premiums by an average of 70%, and proposed a 280% increase for the following year. That action was taken in response to a great increase in the number of malpractice suits filed against physicians, and escalation of awards made to successful plaintiffs. Meanwhile, other insurance companies were either withdrawing from the professional liability insurance market or drastically restricting their involvement in Illinois.

It was in this context that ISMS established the Illinois State Medical Inter-Insurance Exchange to provide professional liability insurance for its members. ISMIE is a reciprocal insurance exchange owned wholly by the physicians it insures. Only members of ISMS who are insured with ISMIE may serve on its Board of Governors, which establishes all Exchange policies. The company's sole objective is to continue to provide Illinois physicians with professional liability insurance and its guiding principle is to defend all suits that have no merit. This determination is made by a committee composed of physicians with particular expertise in medical-legal problems.

After abandoning Illinois at a bad time, some commercial companies are now returning to the professional liability field, selectively seeking out areas where few claims are made and low risk physician groups. Some of them are offering insurance on the basis of "claims made" rather than "occurrences." In a "claims made" insurance policy, the insured has to be insured with the insurer at the time the claim is filed even though the event to which it refers may have occurred many months or years earlier. If for any reason the physician's insurance is no longer in force with the same company, and no provision has been made for the "tail" coverage, the physician will be solely responsible for all the expenses and awards arising from that suit. "Tail" coverage requires a substantial additional premium to make the expired claims-made coverage equivalent to occurrence form coverage. In "occurrence" type policies, such as those written by ISMIE, if the physician was covered at the time of the occurrence giving rise to the claim, protection will be afforded even if the coverage has long since been terminated. Obviously, there may be considerable variations in premiums depending on what type of insurance coverage is being offered.

It is important to remember that at a time when insurance companies were withdrawing from the professional liability field in Illinois, ISMIE provided Illinois physicians with coverage. Furthermore, the mere presence of a physician-owned insurance company in the state must keep the other commercial insurance companies competitive. The ISMIE deserves the support of all Illinois physicians.

*C. C. Wiggishoff M.D.*

Cyril C. Wiggishoff, M.D., President



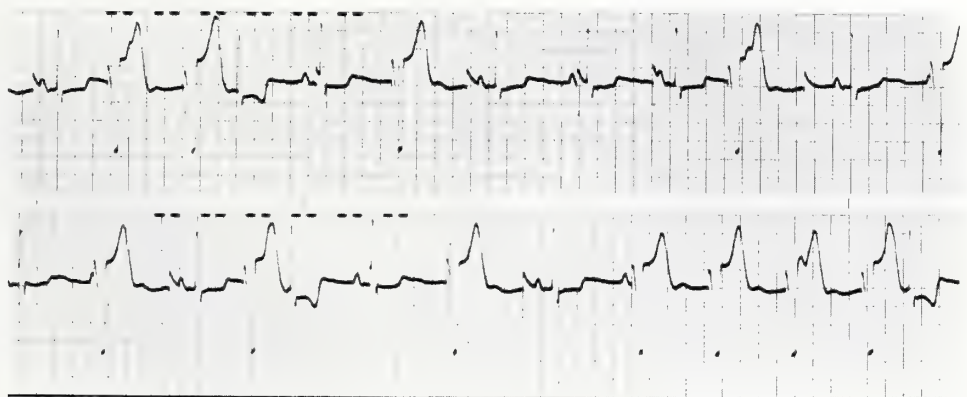
# ***HYPERTENSION:***



# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is an 80 year old lady who developed the sick sinus syndrome manifested by symptomatic marked sinus bradycardia. Her first pacemaker functioned well and was replaced one year ago because of battery failure. She did well until the night before this admission. At this time she complained of the sudden onset of hiccoughs and a pounding abdominal wall. She denied dizziness, light-headedness, chest pain and abdominal pain. Her physical exam was normal except for a slightly irregular pulse. A chest X-ray was ordered. A lead II electrocardiogram rhythm strip was obtained and is shown.*



## Questions:

1. The lead II electrocardiogram rhythm strip shows:

- A. Accelerated idioventricular rhythm.
- B. Pacemaker malfunction, failure to capture the ventricles.
- C. Pacemaker malfunction, failure to sense the preceding QRS.
- D. Intermittent bundle branch block.
- E. None of the above.

2. The most likely reason for this problem is:

- A. Pacemaker battery failure.
- B. Hematoma formation around the pacemaker.
- C. Malposition of the stimulating tip of the electrode catheter.
- D. Acute myocardial infarction.
- E. An increased pacing threshold.

(Continued on page 88)



**BECAUSE  
A THIAZIDE ALONE  
CAN ONLY DO  
SO MUCH...**

**AND YET  
CAN DO  
TOO MUCH.**



# INCREASE CONTROL WITHOUT INCREASING POTASSIUM PROBLEMS.

## **A dependable means to long-term blood pressure control.**


Many times, a diuretic alone can't keep hypertension in check. *INDERIDE*, however, can pick up where thiazide therapy leaves off.

The combination of propranolol HCl, the world's most trusted beta blocker, and hydrochlorothiazide, the standard among diuretics, enables *INDERIDE* to exert an additive antihypertensive effect.<sup>1,2</sup> In fact, a propranolol/hydrochlorothiazide regimen maintained blood pressure below 90 mm Hg in 81.8% to 86.4% of patients followed for 6 to 18 months of therapy.<sup>1</sup>

## **Low thiazide dosage means reduced risk of hypokalemia.**

When thiazides are prescribed in doses greater than 50 mg/day, the potential for hypokalemia increases substantially. What's more, the greater the fall in serum  $K^+$ , the greater the risk of hypokalemia-induced PVCs.<sup>3,4</sup>

With *INDERIDE*, the additive hypotensive effect of propranolol HCl allows the effective dose of hydrochlorothiazide to be kept low (25 mg b.i.d.). And by lowering the daily dose of diuretic, *INDERIDE* also lowers the potential for diuretic-induced side effects. Potassium problems are less likely to occur—yet blood pressure can be controlled consistently.



# **INDERIDE<sup>®</sup>**

Each tablet contains *INDERAL<sup>®</sup>*  
(propranolol HCl) 40 mg or 80 mg,  
and hydrochlorothiazide 25 mg

**B.I.D. 40/25  
80/25**

## **When you know you need more than a thiazide.**

Please see Brief Summary of Prescribing Information on following page.



# INDERIDE®

Each tablet contains **INDERAL**  
(propranolol HCl) 40 mg or 80 mg,  
and hydrochlorothiazide 25 mg

## B.I.D. 40/25 80/25



### BRIEF SUMMARY

(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

**INDERIDE®**  
BRAND OF  
propranolol hydrochloride  
(INDERAL®)  
and hydrochlorothiazide

No. 484—Each **INDERIDE®** 40/25 tablet contains:  
Propranolol hydrochloride (INDERAL®) . . . . . 40 mg  
Hydrochlorothiazide . . . . . 25 mg  
No. 488—Each **INDERIDE®** 80/25 tablet contains:  
Propranolol hydrochloride (INDERAL®) . . . . . 80 mg  
Hydrochlorothiazide . . . . . 25 mg

**WARNING:** This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

**INDICATION:** **INDERIDE** is indicated in the management of hypertension. (See boxed warning.)

**CONTRAINDICATIONS: Propranolol hydrochloride (INDERAL®):** Propranolol hydrochloride is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see **WARNINGS**) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

**Hydrochlorothiazide:** Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

**WARNINGS: Propranolol hydrochloride (INDERAL®):** CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA:** Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

**USE IN PREGNANCY: Propranolol hydrochloride (INDERAL®):** The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in

animal studies at doses about 10 times the maximum recommended human dose.

**Hydrochlorothiazide:** Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**Nursing Mothers:** Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

**PRECAUTIONS: Propranolol hydrochloride (INDERAL®):** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope, attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

**Hydrochlorothiazide:** Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplement salts with foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice. Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

**ADVERSE REACTIONS: Propranolol hydrochloride (INDERAL®):** Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

**Central/Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

**Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

**Respiratory:** bronchospasm.

**Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**Hydrochlorothiazide:** **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

**Central/Nervous System:** dizziness, vertigo, paresthesias, headache, xanthopsia.

**Hematologic:** leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

**Cardiovascular:** orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

**Hypersensitivity:** purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reaction.

**Other:** hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

When severe adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

**HOW SUPPLIED:**—Each hexagonal-shaped, off-white, scored **INDERIDE** 40/25 tablet is embossed with an "I" and imprinted with "INDERIDE 40/25," contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 (NDC 0046-0484-81) and 1,000 (NDC 0046-0484-91). Also in unit dose package of 100 (NDC 0046-0484-99).

—Each hexagonal-shaped, off-white, scored **INDERIDE** 80/25 tablet is embossed with an "I" and imprinted with "INDERIDE 80/25," contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 (NDC 0046-0488-81) and 1,000 (NDC 0046-0488-91). Also in unit dose package of 100 (NDC 0046-0488-99).

The appearance of these tablets is a trademark of Ayerst Laboratories.

Store at room temperature (approximately 25° C).

**Ayerst** AYERST LABORATORIES  
New York, N.Y. 10017

7996/882

# Abstracts of Action

June 26, 1982

The Hamilton  
Itasca, Illinois

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.*

## MEDICAL LICENSURE AND DISCIPLINE

Acting upon an extensive review by the Executive Committee, the Board voted to:

- Ratify: (1) ISMS proposed amendments to the Medical Practice Act to enable the Medical Disciplinary Board to be more effective in identifying and dealing with allegations of physician misconduct or incompetence; and (2) That the Chairman of the Board of Trustees, the President and the Executive Administrator meet with the Governor, the Director of the Department of Registration and Education and the Chairman of the Medical Disciplinary Board to discuss improvement of the Department's existing mechanism to deal with complaints against physicians.

In addition, ratification was given a legislative proposal for mandatory reporting which would: (1) Maintain confidentiality of peer review processes—only findings and pertinent determinations should be reported, and not the process; and (2) Ensure immunity to those involved.

- Ratify a position paper on medical discipline, which identified ISMS activities in this regard over the past decade, and which offered ISMS assistance in effecting discipline. In addition, the paper included support for mandatory reporting.

The Board also concurred with the concept of an applicant for medical licensure in the State of Illinois being required to document that his medical education program is equivalent to the medical education programs accredited by the LCME. Furthermore, the Board recommends presentation of a resolution to this effect in the next meeting of the House of Delegates.

## FINANCIAL MATTERS

After extensive review by the Finance Committee and the Executive Committee, it was determined that policy should be established regarding reserve funds. The Board adopted the financial policy that a permanent reserve fund be established and maintained on a cost basis equal to 50% of the annual gross dues income for a current or future year. Related to this, and consistent with this policy, the Board directed that the accounting records be adjusted to reflect this policy.

The contingency reserve of \$32,722 was transferred to the undesignated fund to provide for reduced values of fixed assets purchased over the past three years for ISMIS. In this regard, accounting procedures for purchase and depreciation of assets were modified to follow IRS guidelines.

*(Continued on page 121)*



# Clinics for Crippled Children Listed for September

Forth-three clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 30 general clinics, 10 cardiac clinics, one for children with neurological problems, 1 for children with scoliosis and 1 for children with myelodysplasia. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- 1 Springfield General - Memorial Med. Bldg.
- 2 Sterling - Community General Hospital
- 2 Effingham - St. Anthony Memorial Hosp.
- 2 Hinsdale - Hinsdale Sanitarium
- 2 Lake County Cardiac - Victory Mem. Hosp.
- 3 Division Cardiac - U. of I. at the Med. Ctr.
- 7 Wheaton - Marianjoy Rehabilitation Hosp.
- 7 Park Ridge General - PM - Lutheran General Hospital
- 7 Park Ridge Cardiac - AM - Lutheran General Hospital
- 8 Carmi - Carmi Township Hospital
- 8 Champaign-Urbana - McKinley Health Service Center
- 8 Joliet - St. Joseph's Hospital
- 8 Chicago Heights General - St. James Hosp.
- 9 Macomb - McDonough Health Department
- 9 Aurora Cardiac - Mercy Center for Health Care Services
- 9 Kankakee General - St. Mary's Hospital
- 10 Hinsdale Scoliosis - Hinsdale Sanitarium
- 13 Belleville - St. Elizabeth Hospital
- 13 Peoria Myelodysplasia - St. Francis Med. Ctr.
- 13 Maywood (Ortho/Ped/Neuro) - Loyola Medical Center
- 13 Chicago Heights Cardiac - St. James Hosp.
- 14 East St. Louis - Community Hospital
- 14 Peoria General - St. Francis Med. Ctr.
- 15 Springfield Ped-Neuro - Memorial Med. Bldg.
- 15 Evergreen Park - Little Company of Mary Hospital
- 16 Rockford - Rockford Memorial Hospital
- 16 Centralia - St. Mary's Hospital
- 16 Elmhurst Cardiac - Memorial Hospital of DuPage County
- 17 Kankakee Cardiac - St. Mary's Hospital
- 20 Peoria Cardiac - St. Francis Med. Ctr.
- 20 Maywood - (Ortho/Ped) - Loyola Med. Ctr.
- 21 Rock Island General - Moline Public Hosp.
- 21 Decatur - Decatur Memorial Hospital
- 21 Carrollton - Boyd Memorial Hospital
- 21 Alton - Alton Memorial Hospital
- 22 Elgin - Sherman Hospital
- 22 Chicago Heights General - St. James Hosp.
- 23 West Frankfort - United Mine Worker's of America - Union Hospital
- 23 Champaign Children's Home - Champaign
- 27 Peoria Cardiac - St. Francis Med. Ctr.
- 27 Chicago Heights Cardiac - St. James Hosp.
- 28 Peoria General - St. Francis Med. Ctr.
- 30 Exceptional Care and Training Center - Sterling

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

## Prescribing information

**INDICATIONS** — For management of anxiety disorders or short-term relief of symptoms of anxiety: for symptomatic relief of acute alcohol withdrawal: for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

**CONTRAINDICATIONS** — Known hypersensitivity to the drug. Acute narrow angle glaucoma.

**WARNINGS** — Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

**Pregnancy and Lactation:** Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

**PRECAUTIONS** — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

**ADVERSE REACTIONS** — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

**INTERACTIONS** — Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

**OVERDOSAGE** — Take general measures as for any CNS depressant.

**SUPPLIED** — TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

**REFERENCES** — 1. O'Brien CP: *Proceedings of Symposium, Problem Avoidance with Benzodiazepine Therapy*, Monograph 97-0818:4-9, 1982. 2. Snyder SH: *Proceedings of Symposium, Anxiety: The Therapeutic Dilemma*, Monograph 97-0644:7, 1981. 3. Shader RI et al: *Clin Pharm Therap* 31:180-183, 1982. 4. Hollister LE: *Proceedings of Symposium, Anxiety: The Therapeutic Dilemma*, Monograph 97-0663:11, 1981.

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Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the fol-

lowing style *and order*: Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal*. The *Journal*, however, will secure author permission before authorizing a reprint.

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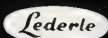
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(If you cannot feel any bumps on the skin, mark this box.)

January 1978 7764-1 A528

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...and no easier method to confirm the results.

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**Indications:** For screening for tuberculosis.

**Precautions:** Use with caution in persons with acute tuberculosis (activation of quiescent lesions is rare); and in patients with known allergy to acacia. Reactivity to the test may be suppressed in those receiving corticosteroids or immunosuppressive agents, or those who have recently been vaccinated with live virus vaccine such as measles, mumps, rubella, polio, etc. With a positive reaction, further diagnostic procedures must be considered, i.e., chest x-ray, microbiologic examinations of sputum and other specimens, confirmation of positive tine test (except vesiculation reactions) by Mantoux method. When vesiculation occurs, the reaction is to be interpreted as strongly positive and a repeat test by the Mantoux method must not be attempted. If a patient has a history of occurrence of vesiculation and necrosis with a previous tuberculin test by any method, tuberculin testing should be avoided. Similar or more severe vesiculation with or without necrosis is likely to occur.

Pregnancy Category C. Animal reproduction studies have not been conducted; whether Tuberculin, Old, TINE TEST<sup>®</sup> can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity is unknown. Tuberculin, Old, TINE TEST should be given to a pregnant woman only if clearly needed. During pregnancy, known positive reactors may demonstrate a negative response.

**Adverse Reactions:** Vesiculation, ulceration, or necrosis may appear at test site in highly sensitive persons. Pain, pruritus and discomfort at test site may be relieved by cold packs or by topical glucocorticoid ointment or cream. Any transient bleeding at puncture site is not significant.



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## EKG

(Continued from page 79)

**Answers: 1. B C 2. C**

The electrocardiogram rhythm strip shows sinus rhythm with some sinus arrhythmia at a rate of 60 beats per minute. There are several sharp deflections seen that occasionally initiate a wide QRS beat at a rate of 72 beats per minute. These spikes are the pacemaker artifacts which occasionally capture the ventricles. Many of the spikes fail to capture the ventricles. In addition, the pacing stimuli have different cycles following the patient's intrinsic QRS so the pacemaker is failing to sense the preceding QRS. At the end of the bottom strip there are four paced beats that follow the patient's own QRS appropriately. If this paced cycle is measured and followed backwards, several stimuli will be found which fail to capture the ventricles. In this case, the cycle following the patient's QRS should have been about equal to the pacing cycle. In many places in the electrocardiogram strip, the pacing spike marches right through the patient's beats. These electrocardiogram findings of intermittent failure to sense and capture, plus the history of sudden onset of hiccoughs and abdominal pounding, strongly suggest malposition of the pacing catheter. In fact, the electrocardiogram would suggest the catheter is moving, sometimes in good position and sometimes not. A chest X-ray showed the catheter had moved forward and was in position to pace the diaphragm. The majority of problems following pacemaker implantation involve surgical complications at the pacemaker site and malposition of the pacing electrode. Infections and hematomas around the pacemaker are avoided by meticulous surgical technique. In this case the catheter electrode appeared on the chest X-ray to have actually penetrated the right ventricle and be in the pericardium. No pericardial friction rub was heard, however. Under fluoroscopy, the pacing catheter was repositioned giving good pacemaker capture and sensing. ◀

# Pulse of the ISMS Auxiliary

*Are You Aware . . .*

## Sexual Exploitation of Children

BY MRS. DONALD HINDERLITER, ISMSA PRESIDENT

Public attention began to focus on the problems of child pornography and child prostitution in 1977.

Time magazine reported in April of 1977 that child pornography had begun to appear sporadically in adult bookstores in the late 1960's.

The Illinois Legislative Investigating Commission was able to document as early as 1973 that young girls were prostituting themselves in Chicago and a significant number of them were under 16.

Sexual child abuse represents exploitation of the weak by the strong more clearly than do other forms of child maltreatment. Kenneth Wooden, in his 1976 study, *WEeping IN THE PLAYTIME OF OTHERS: AMERICA'S INCARCERATED CHILDREN*, says of runaways: "They share a common bond: all are young, troubled, confused and incarcerated—either in institutions or by drugs, pimps or loneliness . . . there are no economic or social boundaries. They are a cross section of American youth."

In 1977, the Chicago Tribune embarked on a

major investigation of the child pornography problem. This was the first of its kind of series and ran in conjunction with a special episode of "60 Minutes."

News media attention, legislative hearings, and books all bring this to public attention. The result is even more media attention, legislative action, and consideration of preventive measures.

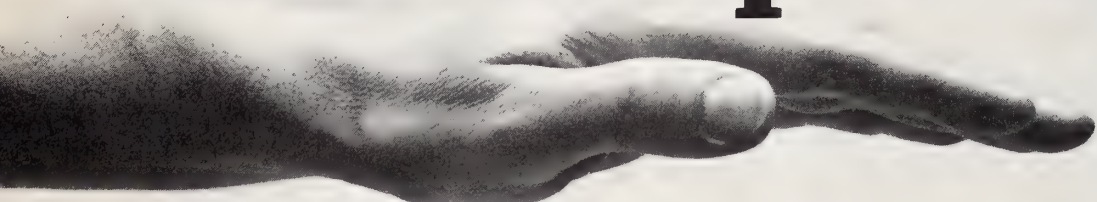
It should be emphasized, however, that "child pornography and prostitution are just symptoms of a larger problem that confronts this country. Against the backdrop of the breakdown of the family and the fundamental values of our society, questions must be asked regarding the adequacy of our educational system, the effectiveness of our social agencies, the ability to deal with poverty and unemployment, and the quality of our justice system." These are two very serious problems, and they are only the tip of the iceberg.

### References

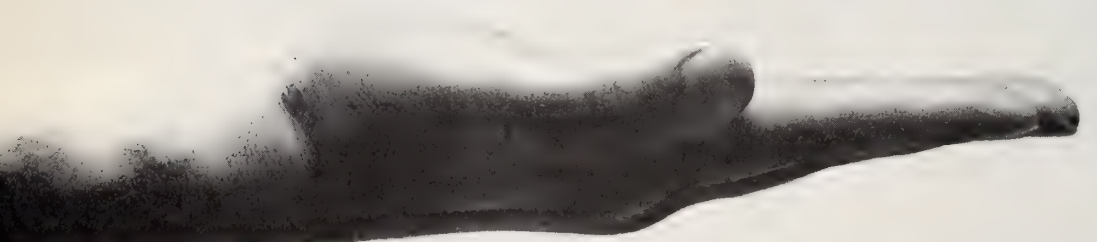
A complete bibliography may be obtained by writing the Illinois Medical Journal, 55 E. Monroe, #3510, Chicago, IL 60603.



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# An added complication... in the treatment of bacterial bronchitis\*



## Brief Summary.

**Consult the package literature for prescribing information.**

**Indications and Usage:** Cefaclor (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

**Lower respiratory infections:** including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

**Contraindication:** Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

**Usage in Pregnancy:** Although no teratogenic or antenatal effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

**Usage in Infancy:** Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefaclor.

## Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Cefaclor.<sup>1-6</sup>

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.<sup>7</sup>

# Cefaclor®

## cefaclor

Pulvules®, 250 and 500 mg

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis, and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefaclor (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship Uncertain:** Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Hepatic:** Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Hematopoietic:** Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

**Renal:** Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

\*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.<sup>8</sup>

**Note:** Cefaclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

## References

1. Antimicrob Agents Chemother. 8:91, 1975
2. Antimicrob Agents Chemother. 11:470, 1977
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5. Current Chemotherapy (edited by W. Siegenhaler and R. Luby), II 880. Washington, D.C. American Society for Microbiology, 1978
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7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett, p. 487. New York: John Wiley & Sons, 1979



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630

200066

# Illinois Society, American Association of Medical Assistants

## An Open Letter To Physicians

ADAPTED FROM AN ARTICLE BY RALPH E. HAGEN, M.D.

As the practice of medicine has become more complex and specialized, the medical assistant has become the physician's most valuable allied health professional—and the American Association of Medical Assistants (AAMA) has become organized medicine's best ally. The professional development offered to its members by AAMA can make the difference between an amateur and a professional office staff member.

Professional medical assistants are committed to self-development and lifelong learning. They are concerned not only with earning a living but also with serving patients.

Qualified medical assistants can perform many administrative, clinical, managerial and supervisory functions, freeing the physician to spend more time in direct patient contact. AAMA is dedicated to the education of this multi-skilled professional. Our organization recognizes that its members must competently adhere to ethical and legal standards of medical practice, respond to medical emergencies and demonstrate professional characteristics.

Medical assistants are the first and last health care professionals to see the patient in the office. They are in a unique position to reflect the philosophy of the office and set the tone for everything that happens there. The medical assistant's impact on a physician's success and efficiency may be even greater than he realizes, for it is the medical assistant who bridges what some have called the greatest communication gap in our society—that between the physician and his patients.

Farsighted and prudent physicians quickly learn that encouraging their medical assistants' educational growth and professionalism is an inexpensive way of promoting self-esteem, loyalty and efficiency. Recognizing the contributions of medical assistants to our practices by supporting their active participation in AAMA and Illinois Society is a simple way to enhance their proficiency and help reduce malpractice claims. With increased competence, medical assistants enable physicians to enlarge the scope and quality of their services. It is to the physician's advantage to encourage membership in this organization.

According to its bylaws, AAMA is not, nor can it ever become, a union or collective bargaining agency. In addition, the association has been commended by the American Medical Association on six separate occasions.

For further information, I encourage you to contact Janet Binkowski, RN, President, Illinois Society, 428 Adams Street, Dolton, Illinois 60419, or Ruby Jackson, CMA, 7337 South Shore Drive #625, Chicago, Illinois 60649, Chairman, Public Relations Committee. The investment of your time today can result in physicians, medical assistants and patients all benefiting as AAMA helps its members fulfill their professional obligations. ◀

*Ralph E. Hagan, M.D. is a board certified neurosurgeon affiliated with Neurosurgical Associates, S.C. in Richmond, Virginia and Vice Chairman AAMA Physician-Advisory board.*



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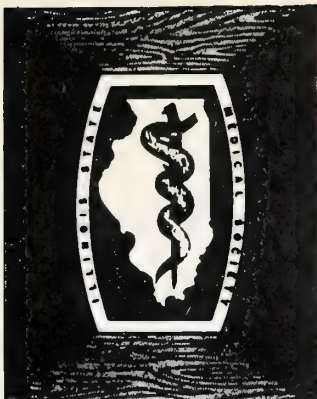
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# I M J

Illinois Medical Journal

Volume 162, No. 2, August 1982

## Follow-up Study

# Infants Surviving Neonatal Intensive Care

BY TIM C. MILLER, M.D. AND BARBARA H. BUSH, PH.D./PEORIA

*Three hundred ninety-five survivors of neonatal intensive care were admitted to a prospective follow up study. At one year following discharge, 85% were examined. At three years following discharge, 43% were examined. Major neuro-developmental abnormality (abnormal neurologic physical exam and/or Revised Denver Developmental Screening Test failure) was documented in 9.6% of all survivors. Eighty-seven percent of very low birth weight infants showed normal development. These results confirm the recent optimistic follow up reports from other academic centers and support the continued aggressive approach to high risk perinatal management.*

Unprecedented progress in lowering infant mortality has resulted from clinical advances in modern perinatal care. These advances are associated with many of the following medical and social changes occurring between 1965 and 1980: (a) reduction of pregnancies among older women

at high birth orders; (b) increased accessibility to health care; (c) expansion of maternal and infant programs; (d) increased health insurance coverage; (e) improved socioeconomic conditions; (f) promotion of family planning and (g) liberalization of abortion.<sup>1</sup>

Equally important is the development of neonatal intensive care, more recently augmented by high risk maternal-fetal surveillance, infant and maternal transport systems, and regionalization of both perinatal services and educational programs. Physician apathy toward perinatal loss was initially thought to reflect a belief that this loss represented a "work of nature" and that to do otherwise would "preserve the defective and weaken subsequent generations."<sup>2</sup> This attitude has been replaced by aggressive obstetrical and pediatric protocols for preventing fetal and neonatal mortality.<sup>3</sup>

A necessary and inevitable outgrowth of increased neonatal survival is the assessment of the quality of life of survivors. As a result, follow-up programs have become integral components of most perinatal centers.

Increasing attention to the morbidity of neonatal intensive care survivors on a longitudinal basis is reflected in the recent medical literature. The early pessimistic outlook for these survivors<sup>4</sup>



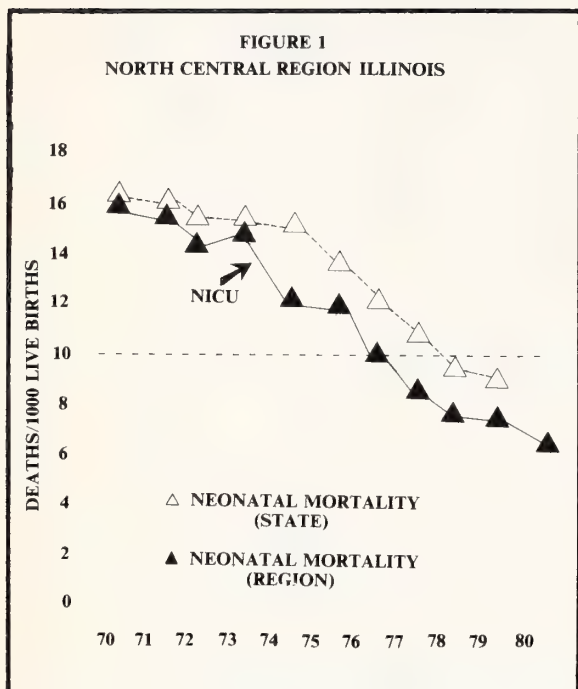
Year of Disabled Persons.

**Barbara H. Bush, Ph.D.**, is a research associate in pediatrics affiliated with the University of Illinois College of Medicine-Peoria and St. Francis Hospital-Medical Center in that city. She is also assistant to the director of medical education for continuing medical education at St. Francis and has served as vice chairman on the education task force, Peoria chapter, International



**TIM C. MILLER, M.D.**, is a board certified pediatrician and assistant professor of pediatrics, University of Illinois College of Medicine-Peoria. Certified also in the subspecialty of fetal-neonatal medicine, Dr. Miller is director of the Perinatal Center, North Central Perinatal Region, St. Francis Hospital Medical Center.





has been largely replaced by guarded optimism.<sup>5,6</sup> Continuing controversy exists, however, when some handicaps are recognized as increasingly associated with select groups of neonatal survivors.<sup>7</sup>

The purposes of establishing a follow-up program at this perinatal center were two-fold: (1) to determine the incidence of subsequent disabling conditions and health problems in high risk Peoria infants who survived neonatal intensive care and (2) to provide a means of early identification of disabling conditions so that children could receive the appropriate services before reaching school age.

### Perinatal Center Described

In 1943, St. Francis Hospital accepted responsibility for providing care for premature infants born in a large downstate area of Illinois. This effort was supported by the Illinois Department of Public Health and is recognized as one of the first state supported Premature Care Programs.<sup>8</sup> Subsequently, the program was expanded to provide care for high risk infants (1969) and finally high risk mothers (1975) residing in a 23-county area of North Central Illinois. The impact of this neonatal intensive care capability is clearly de-

linedated by the almost immediate decrease in neonatal mortality (Figure 1).

Three hospitals within Peoria itself provide maternity-infant services. Approximately 30% of the total regional deliveries occurred in these three hospitals. Although maternal referrals were beginning to occur from outside of Peoria, the total number of such "intrauterine transfers" was less than 20 each year of the study period. (None of these neonates were enrolled in the subsequent follow-up project.)

During this period, the overall neonatal mortality rate for all Peoria infants was 10.3 (1.03%). Low birth weight (< 2500 grams) rate was 7.2%. Birth weight specific survival for these low birth weight infants during the three year period was: (a) < 1000 grams—10% (b) 1001 to 1500 grams—68% and (c) 1501 to 2500 grams—96.5%.

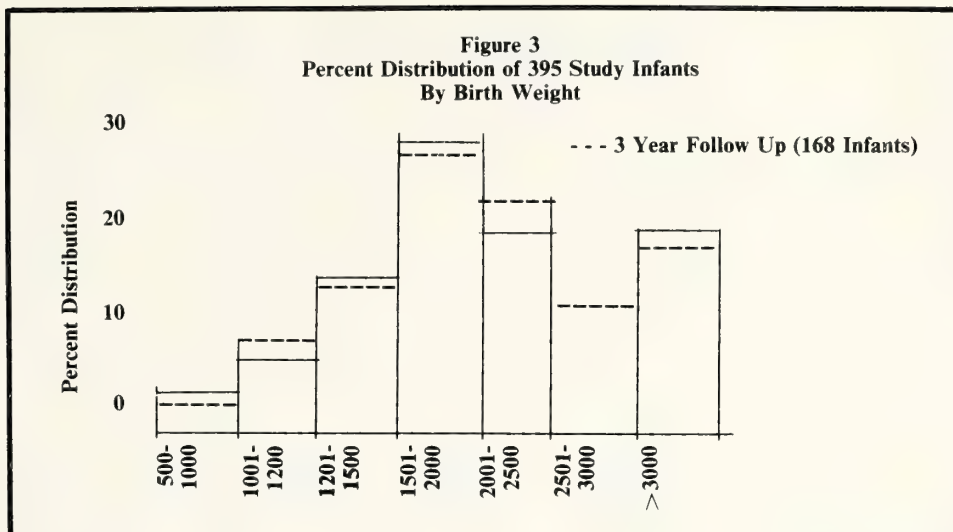
### Methods

*Sample:* The High Risk Group consisted of 395 infants discharged from the Neonatal Intensive Care Unit (NICU) over a three year period.

Initially, 6.4% of the total live born infants were admitted to the NICU from three Peoria hospitals. Survival rate of these admissions was 89%. All survivors were characterized by one or more of the entry criteria listed in Figure 2. The following groups of infants were eliminated from the study: (1) infants with transient neonatal adaptation problems admitted for observation or intermediate care and (2) infants with congenital and chromosomal anomalies known to affect the central nervous system. The 395 infants thus represented 42% of the NICU survivors with true intensive care conditions.

**Figure 2**  
**Reason for Admission to Study**

- 1 = Birth weight (<1814 grams)
- 2 = Maternal Diabetes on Insulin
- 3 = Congenital malformation (excluding central nervous system)
- 4 = Neonatal septicemia or meningitis
- 5 = Hypoglycemia
- 6 = Intrauterine acquired infections
- 7 = Hyaline Membrane Disease
- 8 = Atelectasis
- 9 = Asphyxia neonatorum
- 10 = Pneumothorax
- 11 = Pneumomedia stinum
- 12 = Prolonged apnea
- 13 = Assisted ventilation
- 14 = Meconium aspiration
- 15 = Seizures



The control group consisted of 203 normal, term infants without neonatal complications. They represented infants consecutively born at the same three hospitals during the same time period that high risk infants were born.

**Follow-up Procedures:** On hospital discharge, perinatal data were recorded from the medical records of the high risk infants. These included maternal health status, characteristics of the pregnancy, labor, and delivery, birth weight, status of the infant at birth, status of the infant in the intensive care nursery, procedures and therapy performed, and medications administered to the infant.

A follow up clinic was established one day a week, staffed by a pediatrician and a nurse trained in developmental assessment. Children attended this clinic on or near their first and third birthdays. The format was identical at both one and three years of age and consisted of the following data collection techniques.

**Medical History and Physical Examination—**Information was recorded concerning respiratory problems, hospitalizations, emergency room visits, medications, and other indices of general health. A complete physical examination of each child was performed by the attending pediatrician. All abnormalities were recorded.

**The Revised Denver Developmental Screening Test (RDDST)—**This test was administered to each child at the follow up clinic by a trained nurse or psychologist in the presence of one or both parents. The four areas of development assessed on the RDDST are Personal-Social, Fine Motor-Adaptive, Gross Motor, and Language.

Each child was classified as normal, abnormal, or questionable according to accepted criteria.<sup>9</sup> An additional category, untestable, was created for a child who refused to perform tasks in sufficient numbers to validate the results.

Infants assessed as questionable were given re-turn appointments in two to three months. Several of these children were subsequently found to be developing normally. These children were then reclassified as normal when last examined, even if they were not examined at three years of age.

## Results

**Population:** Birth weight distribution of the 395 high risk infants is depicted in Figure 3. Comparison of the percent incidence of selected hospitalization data is shown in Table 1. In addition, 13% of these infants exhibited either congenital or acquired heart disease, 8% required major surgery, 7% received an exchange transfusion, 5% were diagnosed as having proven or clinically suspected sepsis, 4% developed intracranial hemorrhage, and 1% developed necrotizing enterocolitis. Both cases of retrolento-fibrous dysplasia regressed without developing significant retinal damage. None of the control infants had any neonatal problems.

**Children Lost to Follow Up:** Of the 395 high risk infants enrolled in the study, 334 (85%) were examined at one year of age. One hundred sixty-eight of the infants seen at one year were then re-examined at three years of age. Thus, 43% of all high risk infants initially enrolled in the project were followed until the three year exam. An attempt was made to detect any hospitalization parameters which were more common in either the infants who were lost or those who completed



**Table 1**  
**Hospitalization Data of 395 Survivors**  
**Of Neonatal Intensive Care**

	<u>No.</u>	<u>% Total Survivors</u>
<b>A. Gestation</b>		
1. Preterm	299	76
2. Term	87	22
3. Post-term	9	2
<b>B. Sex</b>		
1. Male	229	58
2. Female	166	42
<b>C. Race</b>		
1. Caucasian	341	86
2. Black	47	12
3. Other	7	2
<b>D. Intrauterine growth*</b>		
1. AGA	287	73
2. SGA	89	22
3. LGA	19	5
<b>E. Resuscitation at Delivery</b>		
1. Suctioning of larynx	15	4
2. Bag and mask	64	16
3. Intubation	44	11
<b>F. Ventilator assistance*</b>		
1. IPPB	116	29
2. CPAP	98	25
3. Chest tube	29	7
<b>G. Respiratory illnesses*</b>		
1. HMD	122	31
2. Pneumonia	70	18
3. Other	80	20
<b>H. Central Nervous System Illnesses*</b>		
1. ICH	16	4
2. Seizures	14	4
3. RLF	2	0.5

\*AGA, SGA, LGA = Appropriate, small, and large for gestational age; IPPB = Intermittent Positive Pressure Breathing; CPAP = Continuous Positive Airway Pressure; HMD = Hyaline Membrane Disease; ICH = Intracranial hemorrhage; RLF = Retrolental fibroplasia

the follow up. None were demonstrated. Figure 3 depicts that birth weight distribution remained constant throughout the follow-up interval.

Two hundred and three control infants were seen at one year and 81 of these completed the follow-up at three years.

**Mortality:** A total of eight high risk infants died after being discharged from the Neonatal Intensive Care Unit. Five of these children died before one year of age and were never examined in follow up. The cause of death in four of these infants was related to a congenital anomaly and the remaining death was related to perinatal events. The remaining three deaths were related to perinatal diseases and occurred after the first year.

**Neurological Abnormalities:** The following major neuromuscular abnormalities were recorded on physical examination: definite or suspected cerebral palsy, seizures, significant hearing loss, hydrocephalus (arrested or with ventriculo-

peritoneal shunt), microcephaly, sixth cranial nerve palsy, and chronic nystigmus. At year one, 5% (16/334) of the study infants had at least one of the above abnormalities. At year three, abnormalities were present in 7% (11/168) of the infants.

A total of 25 different high risk infants showed neurologic abnormalities either throughout the entire study interval or at the time they were last examined.

Three control infants had abnormal physical findings: (a) fixed dilated pupil following meningitis during infancy, (b) possible hearing loss from chronic otitis media and (c) possible seizure disorder on medicine following several febrile seizures.

**Revised Denver Developmental Screening Test (RDDST):** Figure 4 depicts the distribution of high risk and control infants by their performance on the RDDST. Since the percentage of control

**Figure 4**  
**Percent Distribution of Study and Control Infants**  
**By Results of Revised**  
**Denver Developmental Screening Test**

		Normal	Abnormal	Questionable	Untestable
YEAR 1	Study N=334	88%	3.9%	8.1%	---
	Control N=203	99%	---	1%	---
YEAR 3	Study N=168	78%	4%	2%	16%
	Control N=81	89%	---	1%	10%

infants showing abnormal or questionable results was so small, no statistical comparisons were attempted.

For purposes of this study, abnormal and questionable test results were classified as less than normal. Examination of the group of children determined to be untestable indicated that: (a) none showed neurological abnormalities on pediatric examination and (b) none were abnormal and only two were questionable on the RDDST at one year of age. For this reason, this untestable

group of children was included as normal in the overall study results.

In the high risk population, 88% of the infants at one year and 94% of the children at three years were developing normally. This compared to 99% of the control infants at both study periods.

Of the 334 infants examined at least one time, 308 were developing normally by the RDDST when last seen (281 normal, 27 untestable). Conversely, 26 children (8%) were exhibiting abnormal or questionable development at the time of their last examination.

Only three control infants at one year and one control child at three years had questionable results on the RDDST.

When high risk children with abnormal neurological findings and/or developmental testing of any degree less than normal were combined, there were a total of 47 children identified. Fifteen of these infants showed normal testing at their last exam (between one and three years). Therefore, 32 infants remained with less than normal outcome when last examined. This represents only 9.6% (32/334) of the entire study population.

*Low Birth Weight (LBW) and Very Low Birth Weight (VLBW) Follow Up:* A total of 230 and 113 infants, examined at one and three years respectively, had low birth weights (< 2500 grams). The handicap at each of these years was 14% and 13% respectively (Figure 5).

At one and three years respectively, 69 and 35 infants weighing less than 1500 grams (3 lb 5 oz) were examined. Infants in this birth weight category are now classified as very low birth weight. Handicaps were demonstrated in 13% of these infants at one year and in 20% of the children at three years of age (Figure 5). Two infants died

**Figure 5**  
**Percent Handicap\* in Low Birth Weight Infants**

Birth Weight (grams)	YEAR 1			YEAR 3		
	Handicaps	Infants Examined	Percent Handicap	Handicaps	Infants Examined	Percent Handicap
< 1000	0	5	0%	0	2	0%
1001- 1200	4	17	24%	2	11	18%
1201- 1500	5	47	11%	5	22	23%
1501- 2000	11	94	12%	2	44	5%
2001- 2500	12	67	18%	6	34	18%
TOTAL	32	230	14%	15	113	13%

\*Handicap = Abnormal neuromuscular physical exam and/or less than normal Revised Denver Developmental Screening Test.



between one and three years of age and an additional two infants who were classified as abnormal at one year were reclassified as normal at the three year examination.

A total of nine infants remained handicapped when last examined. Therefore, this study demonstrated that 13% (9/69) VLBW infants showed some degree of physical or developmental handicap.

## Discussion

Many of the difficulties in design and analysis of high risk infant follow up studies have now been clearly identified.<sup>10</sup> The heterogeneity of our study population makes overall interpretation equally difficult. However, several findings in this follow up program allow at least preliminary comment on the incidence of major neuro-developmental handicaps.

As expected, the major factor associated with NICU care was low birth weight (< 2500 grams), and the number of infants available for examination remained at 70% throughout the three year follow up interval. Recent evidence suggests that the major factor predicting neonatal mortality is the rate of VLBW infants, rather than LBW infants, born in the region under study.<sup>11</sup> Total morbidity in this group of infants appears to be decreasing significantly.<sup>6</sup> However, the outlook for subgroups of low birth weight infants, namely those below 1000 grams birth weight, remains of concern when aggressive medical approaches are undertaken.<sup>7</sup>

Our follow up information confirms the optimistic outlook for low birth weight infants. The overall major neuro-developmental handicap rate of 13-14% is comparable with most recent publications. It is impossible to address the problem of infants weighing less than 1000 grams from our data. Far too few babies have been examined and the overall survival rate of 10% for these infants in 1974-77 does not approach the improved survival rates accomplished in the last two years.

The use of the RDDST along with a general pediatric exam was recognized as only a screening tool for major neuro-developmental disorders. Previous publication of the correlation between the RDDST and more sophisticated developmental testing was .68 in reporting children as abnormal and .92 in reporting normalcy only.<sup>9</sup> No attempt was made in our population to identify more subtle forms of minimal brain dysfunction.

Of particular interest to these researchers is the fairly consistent percentage of three year old children, both in study and control groups, who were

"untestable" in an outpatient setting. These children will be followed closely in school to determine if this "untestability" is an early signal for learning disability in later years.

This study confirms the findings of others who have adopted an optimistic approach to infants admitted to neonatal intensive care units for serious illness. Further, it reaffirms the need for regionalized perinatal systems staffed with qualified physicians and nurses. A cohort of survivors has been identified at this institution which can now be compared to successive groups of survivors who have benefited from increased technological and system advances in the provision of perinatal care. Outcome data such as these continue to influence the aggressiveness with which the medical profession approaches the high risk mother and her fetus.

## Acknowledgment

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## Policing the Profession

*On Sunday, May 9, the Chicago Tribune broke a five part series detailing alleged problems with medical discipline in Illinois. The Tribune's investigative task force explored the mechanics of medical discipline as administered under the Medical Practice Act by the Illinois Department of Registration and Education (R&E). That newspaper series followed a WBBM-TV series on the impaired physician by only a few days. In a week's time, ISMS and the medical profession received unprecedented media coverage. The following interview with ISMS President Cyril C. Wiggishoff was conducted during this hectic period, in an attempt to share this experience with our readers.*

*The text of the ISMS position paper on medical discipline is reprinted on page 106. The editors emphasize that while that document, and the thinking reflected in Dr. Wiggishoff's comments below, were relevant to Senate Bill 1614, that bill has not yet been signed into law by the Governor. It was not possible at press time to predict the content of the final bill, if signed.*

**IMJ:** *Your first two months as ISMS president have witnessed an extraordinary level of media attention for the Society and the profession generally. Specifically, you've been asked to respond to a Chicago Tribune series which documented problems in the State of Illinois' medical discipline system and dramatized cases of alleged incompetence and/or misconduct. What do you consider to be the overall value of such efforts as that Tribune exposé? Do you feel the public is served by investigative media reports?*

**Dr. Wiggishoff:** I don't really know what precipitated their investigation, but it's certainly in accordance with our concern about the way in which medical discipline has been conducted in the state of Illinois. It may be just a coincidence, but it really comes at a very appropriate time in terms of the ISMS efforts. These culminated recently in communications to both the director of R&E and to the governor about the poor way in which medical discipline was being conducted by the state.

I think that these investigations are effective, if only to pinpoint the public's attention or even the profession's attention, to the problems. Unfortunately, they are not always very accurate and despite the fact that they are supposed to be in-depth, they rarely are in-depth investigations. But I think that in this case, the *Tribune* series conducted by their task force was certainly very effective in focusing the attention of both the public and state agencies on defects in the implementation of the 1976

Act which created the Medical Disciplinary Board.

**IMJ:** *In response to that Tribune series, you testified before the House Registration and Regulation committee and proposed legislation that would require reporting of physician misconduct or incompetence. That legislation would require that all malpractice suits of any amount be reported to the Department's Medical Disciplinary Board. Is it really in the physician's best interest to report all malpractice suits, regardless of how frivolous or minimal some might be?*

**Dr. Wiggishoff:** The medical society has been struggling with this particular issue. We have recommended that no dollar amount be used as a standard for malpractice suits to be reported to the Medical Disciplinary Board. That suggestion sought to avoid establishment of a dollar-amount standard for "gross malpractice." Definitions of that kind are generally self-defeating.

Under this bill, every settlement will be reported to the Board. The Medical Disciplinary Board will then investigate. Some of these settlements are made in order to save the cost of litigation rather than because of any physician culpability. Those cases will be rejected.

It is important to emphasize that each of these reports will be reviewed by the Medical Disciplinary Board members, who are physicians. They will apply medical, rather than bureaucratic criteria, in examining them. The doctor/patient relationship remains protected under this

system, and frivolous reports will be weeded out while valid ones will come to light. As it is envisioned, the medical society's proposal would protect physicians from unfair accusations and isolate those requiring thorough investigation and follow-through by the Department.

In instances where the Medical Disciplinary Board believes that there may be some bad practice or malfeasance on the part of a physician, the Department has the power to investigate further. They have subpoena powers and they have investigators. That's why the medical society did not want to put a dollar figure on the cases that have to be reported. Obviously, a lot of the cases will have no merit at all. Many are settled in order to save money.

**IMJ:** *Why do you feel that this legislation is necessary?*

**Dr. Wiggishoff:** The accusation that is made constantly, and I think possibly with some justification, is that physicians are reluctant to report other physicians whom they know are not practicing up to ideal standards. Also, while there are impaired physician committees at most hospitals, there are also physicians who refuse to enter the impaired physician programs.

Let us recognize right away that impaired physicians are sick people. An impaired physician, one who is suffering from alcoholism or drug abuse or who has some psychiatric problem, should be treated as a patient. Those physicians who enter these programs voluntarily should



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***"We feel that a doctor who is not performing his duties because he is impaired for some reason should be treated. If he's not performing his duties properly because he has not kept up with the times . . . we want him re-educated. We are not out to punish people. That's not our job."***

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have their privileges curtailed during the time of their treatment and have their privileges reinstated once they are rehabilitated.

However, there are some physicians who will not recognize that they are sick, and refuse to enter the program. At the present time there is very little that can be done about them. If this legislation is passed, it will be necessary for the hospital where they hold their medical staff privileges to report them to the State of Illinois director of Registration and Education. At that time, presumably, the director will say to them, "either you enter a program and be treated or we will suspend your license." Then they can't practice medicine and cannot do harm to the public.

**IMJ:** *So in fact this is not a departure from the medical society's attitude toward physician impairment, which has always been supportive and therapeutically oriented, but instead just a way of dealing with those who might slip through the cracks.*

**Dr. Wiggishoff:** That is correct. The whole attitude of the Illinois State Medical Society is one of rehabilitation and re-education. We feel that a doctor who is not performing his duties because he is impaired for some reason should be treated. If he's not performing his duties properly because he has not kept up with the times and his education has fallen behind, then we

want him re-educated. We are not out to punish people. That's not our job.

**IMJ:** *Do you feel that the fact that the medical society is proposing this legislation could be taken to imply that physicians have failed in their job of policing their peers?*

**Dr. Wiggishoff:** It could be taken that way but that would not in fact be so. We have a long record of having sponsored legislation to improve the discipline of physicians. The bill that was introduced in 1976 was passed unanimously, both in the House and the Senate. The bill now under discussion\* refines that Medical Disciplinary Board bill by making certain agencies responsible for reporting physicians who are not practicing properly. Hopefully this bill will pass unanimously as well. (\*Editor's note: **At press time, Senate Bill 1614 had passed both Houses and awaited the Governor's signature**)

**IMJ:** *One thing we've begun to see is a public conception that the medical society has police powers or legal subpoena-type powers which it does not in fact have. It might be helpful to our readers if you could outline some of the steps that have been taken through this bill to reinforce what the legislature and the department can do but the medical society cannot do.*

**Dr. Wiggishoff:** When the Medical Disciplinary Board was originally established, it was supposed to have investigators who would be sent out to investigate complaints against

physicians. It was supposed to have a medical coordinator who was a physician and who was supposed to work for the Board. All cases were supposed to be referred to the Board, which would then make a recommendation to the director, the only individual who can revoke or suspend a license.

In point of fact, it never worked out that way. First of all, insufficient medical investigators were employed. They were unskilled in their jobs and sometimes the medical coordinator did not refer to the Board at all. Very often, he bypassed the Board. The medical society had cause to complain to the director of Registration and Education, that plea-bargaining was going on between the medical coordinator and physicians who were guilty of drug peddling and other bad practices. It appeared that very often the penalty invoked was considerably less than probably would have resulted from investigation by the Board. We have brought this to the director's attention and re-emphasized our position in the hope that these defects in the bureaucratic mechanics would be improved.

**IMJ:** *In addition, mandatory reporting mechanisms, both by private agencies to the department and then back to those consumer or professional groups by the department could be expected to reinforce the impact.*

**Dr. Wiggishoff:** That's right. I'm sure that when and if this is imple-



mented there will be more physicians' names coming to the director. I think there is going to be more work for him to do. I believe that the director has employed more people. The medical society has stated publicly that it will assist the director in training medical investigators to help them determine what is bad medical practice. The medical society has also gone on record in telling the director that we will provide experienced physicians to review some of the cases initially. We can provide reviewers to determine which reports are of a serious nature and need immediate attention, which should be referred to the Medical Disciplinary Board on an urgent basis and which are less urgent, or even trivial, and require no further investigation. There are going to be an awful lot of reports, and quite a number of physicians' names coming from the various liability insurance companies. All these settlements will have to be reviewed.

Maybe this is going to be beyond the immediate capabilities of the department but don't forget, the department is really quite well funded to perform this. Three or four years ago, the Illinois State Medical Society agreed to a quadrupling of the physician's licensing fees from \$10 to \$41.50 every two years. That money is supposed to be set aside in a special fund at the sole discretion of the director to be used in policing the

medical profession. In point of fact, over a million dollars of that fund had not been used at the time of the last licensing period. So hopefully he'll be able to do the job.

**IMJ:** *Let's return to the general question of communication with the public and the public image of the profession. Do you believe that the medical profession's image has benefited from participation in such programs as the television news series on the impaired physician, the newspaper exposé follow-up's or Phil Donahue's program on malpractice? Is this what we should be doing as a professional society?*

**Dr. Wiggishoff:** I think so. It's obvious that the profession does not enjoy the same high image that it did in the past. There has been slippage. We are still held in high esteem by the public but nowhere near what it was when my father was in practice. And there are good reasons for that. I think that the principle reason is that the public is much more sophisticated as far as health matters are concerned. They are much less likely to accept what people tell them in every respect. Also, 30-40 years ago, medicine was much more of an art, so there was a lot more of the "laying on of the hands," sort of thing. In many cases there wasn't too much that one could actually do. A lot of the healing art was talking to people, listening to people and being

a sort of father confessor to them. In that way, physicians established a fine rapport with their patients.

Nowadays, doctors are much more like technicians. They do things to people. Lots of the things they do are rather unpleasant. And obviously, when you're doing things to people, things can go wrong. The equipment can go wrong or the doctor may do the procedure incorrectly. And as a result of that there is a certain degree of suspicion. There is a barrier between the patient and the physician.

I think that physicians should not only be speaking to newspaper reporters and appearing on T.V. shows, but they should be active in their communities. It shouldn't appear that they presume themselves to be above other people. They are just ordinary citizens like everybody else and they should go out and demonstrate that.

**IMJ:** *You say that physicians should demonstrate that they are ordinary citizens. If that's the case, do you consider involvement in political activity part of a physician's duty as a citizen? After all, the AMA was attacked in a recent television editorial which implied that campaign contributions to certain congressmen could be tied to some of the congressmen's actions. What about the media's perception that there is something wrong with giving contributions to political candidates?*




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***"I think that physicians should not only be speaking to newspaper reporters and appearing on T.V. shows, but they should be active in their communities. It shouldn't appear that they presume themselves to be above other people. They are just ordinary citizens like everybody else and they should go out and demonstrate that."***

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***"Politicians have an obsession with numbers. If you represent a large organization you get their attention much more . . . The strength of our voice depends entirely on the strength of our membership."***

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**Dr. Wiggishoff:** I understand the implication is that you are buying someone's vote. I suppose there are some crooked legislators. We saw some in ABSCAM, but those who are really crooked hardly sold their votes for a few thousand dollars. So I don't think that is a very legitimate observation.

When the Illinois State Medical Society Political Action Committee board votes to contribute to a political candidate's election, they aren't buying a vote, they're supporting a general philosophy. In many cases, we might not agree with everything a legislator supports. We seek to support those candidates who share our philosophical orientation on issues relevant to health care.

The fact is that it is very expensive to run a political campaign these days. Television time is often tens of thousands of dollars for just a few seconds. Unless we only want well-to-do people who either have money of their own or are members of rich sponsoring organizations to be our legislators, the rest of us have to put out money for those candidates who we think will do a good job representing us but don't have this kind of support. That's part of the political scene in this country.

Fund-raising is a big part of politics in the United States. And I think it's beholden on all citizens to make some kind of contribution. When you make a contribution to your church pastor, are you buying his vote for your place in heaven? No. You want him to do some good work

for the community. I think this should be the attitude toward political contributions. As citizens, it's beholden on us to support good people, and to provide the funds to get them to the congress or to the state legislature.

**IMJ:** *As a spokesman for the medical society, what would you have to say to the county leadership and the general membership about their obligation to assist efforts to reform medical discipline and also to participate as citizens in the community?*

**Dr. Wiggishoff:** I don't think we have to exhort the members of the medical society to be interested in medical discipline. In the last few years, polls of the state medical society and of the Chicago Medical Society demonstrated quite clearly that the biggest single objective that the members had was to discipline the bad doctors. They are sick and tired of being tarred with the brush that tars the bad doctors. They don't view themselves in that light and they want to demonstrate that most of the physicians in their communities are practicing good medicine and are honorable and ethical individuals. They want a fair, objective, effective disciplinary system that protects good doctors from unfair accusations and weeds out the bad doctors. So I don't think we have to worry about the disciplinary part of it.

I think that what we need to do is to convince the physicians who are members of the society to persuade their colleagues who are not mem-

bers to join our ranks. Now, there is a lot of dissension on any issue in the medical society. You can't be all things to all people. Certainly everyone doesn't always agree on everything the AMA does or everything that the Illinois State Medical Society supports. Still, our overriding responsibility to our profession resides in those two groups. We should be members of those organizations.

My message to the leadership and even more to the individuals who are just dues-paying members, is this: Get your colleagues who are not members to join the organization. Make sure that they know of the important, but intangible benefits of medical society membership, such as representation in Springfield and Washington and negotiation services with government and private third party payers. Non-members do benefit from many of these programs; it's up to the members to recruit colleagues to pay their fair share. It's an important part of their professional commitment. We need their support, we need the funds that they would generate and we need their numbers.

Politicians have an obsession with numbers. If you represent a large organization, you get their attention much more than if you represent a small organization. The more attention we can bring to health issues the more we can protect our patients from things like inadequate enforcement of laws to provide medical discipline. The strength of our voice depends entirely on the strength of our membership. ◀



# Special Articles

## Position Paper on Medical Discipline

*On June 14, 1982, ISMS President Cyril C. Wiggishoff, M.D., testified for the Society before a special subcommittee of the Illinois House of Representatives' Registration and Regulation Committee. The hearings were held in response to a Chicago Tribune series detailing problems with medical discipline in Illinois. The result of those hearings was development of Senate Bill 1614, which at this writing had been passed by both houses and awaited the Governor's signature to become law. The editors emphasize that it was not possible at press time to predict whether or not the bill would be signed. If it is signed, the bill, which incorporates many of the suggested provisions below, would not become law until January, 1983.*

*Dr. Wiggishoff's testimony was based on the following position paper, ratified by the ISMS Board of Trustees. His additional comments on the issue are included in this month's IMJ interview, beginning on page 102.*

The recent *Chicago Tribune* series on the Department of Registration and Education's handling of medical discipline in Illinois has underscored a problem about which the Illinois State Medical Society has expressed concern for the past several years.

ISMS—and the overwhelming majority of the state's physicians—continue to favor a strong medical disciplinary system to weed out incompetent practitioners. The Society is anxious to work with the Department of Registration and Education, Governor and General Assembly to help improve the state's ability to protect the public from bad doctors.

We believe that efforts to address this serious problem should center around three major focal points:

*Improvement of the Department of Registration and Education's existing mechanism to deal with complaints against physicians.*

*Revisions in the Medical Practice Act to enable the Medical Disciplinary Board to be more effective in identifying and dealing with allegations of physician misconduct or incompetence.*

*Reporting to the state of final action taken in which physician unprofessional conduct, incompetence or inability to practice has been determined.*

### The Existing Mechanism

Inefficiency in the Department of R&E's handling of physician complaints has been of concern to ISMS since the current medical disciplinary

system took effect in 1976. For example:

*In July, 1978, ISMS publicly objected to the Department's practice of allowing its medical coordinator to bypass the disciplinary board. At that time, the Society chastised the Department for permitting the medical coordinator to secure "consent orders" in which a physician would voluntarily surrender his license for a prescribed period to avoid a suspension or revocation. License suspensions handled unilaterally by the medical coordinator often precluded harsher penalties. Furthermore, on numerous occasions, the medical coordinator allowed the statute of limitations to run out on cases that could have proceeded to formal complaint.*

*ISMS repeated its concern to the Department in July, 1979. Later that year, an audit ordered by the Illinois Auditor General sharply criticized the Department for its ineffectiveness. Following the auditor's report, the Department director was replaced, and ISMS again advised the Department of Registration and Education of the Society's concern that appropriate discipline be effected in a timely fashion.*

*In 1980, ISMS recommended that the Department hire an independent attorney for the Medical Disciplinary Board. The special counsel was intended to provide an analysis of cases, draft rules and procedures, advise the Board on legal issues and facilitate interactions with the Department's attorneys.*

*Last year, ISMS sent a letter to Illinois*

Governor James R. Thompson, expressing to him the Society's concern over bureaucratic problems within the Department. Those problems included inadequate staff support which caused long delays in investigating and processing complaints. Later in the year, the Society began informal meetings with Department staff in an attempt to reduce delays in receiving notices of disciplinary actions. Licensure suspensions and revocations have been published when available in the *Illinois Medical Journal* which is published by ISMS for its 15,000 physician members and also distributed to all Illinois hospitals and other state medical societies.

*Meetings with the Department have continued since the beginning of 1982.* It is only since the appointment of Gary Clayton as Director that the Department has exhibited any inclination to seek the assistance of ISMS in effectively implementing the disciplinary law.

While the state's handling of incompetent physicians has been questioned, ISMS would vigorously refute charges that the basic structure of the medical disciplinary system in Illinois is inadequate. All facets of the existing law simply have not been efficiently utilized to their fullest extent.

When initially established, and in keeping with the Medical Practice Act, the Medical Disciplinary Board was perceived as a semi-autonomous entity, providing peer review in a setting analogous to a grand jury system. It was to receive all complaints, to direct all investigations, and to weigh any evidence of wrongdoing. A bureaucratic overlay seems to have hindered implementation according to the Act.

Restructuring of the system is necessary. The Medical Disciplinary Board must have the authority granted by the Act in order to carry out its public mandate. However, ISMS does not believe that public representation on the Board should be a part of this restructuring. The evaluation of physician practice must be accomplished by those with proper clinical training.

We remain convinced that a medical disciplinary board system is a sound approach. However, the Department of R&E has not given the Medical Disciplinary Board appropriate authority to address problems of physician misconduct and incompetence.

The Illinois State Medical Society publicly reaffirms its willingness to assist the state in any way practical to improve its ability to deal with physician incompetence or misconduct. As a

professional association, ISMS has no legal standing with respect to physician licensure. Nonetheless, the Society is willing to make itself available to a restructured Medical Disciplinary Board to help expedite pending claims. For example, ISMS could:

*Provide special physician reviewers for immediate medical evaluation of all pending cases.* This might allow the Department to speed its handling of those cases while still guaranteeing due process to accused physicians.

*Improve the effectiveness of the Department's investigators by educating them as to what constitutes questionable medical practice.*

*Additionally, recognizing the need for change, the ISMS is calling for administrative refinement and modification of the Medical Practice Act, to give the Medical Disciplinary Board authority to carry out its mandate. The Society also today is proposing legislation requiring an appropriate mandatory reporting law.*

However, mandatory reporting by itself will not effectively address the issue of medical discipline. In short, a mandatory reporting law must be accompanied by a disciplinary system that provides proper, equitable disposition of medical discipline cases.

Following are the Society's specific recommendations regarding revision of the Medical Practice Act and mandatory reporting.

### Medical Practice Act Revisions

The Medical Practice Act allows appropriate activity to assess physician performance and to impose sanctions on aberrant behavior. However, minor refinement of the Act would clarify the functions and duties of the Medical Disciplinary Board. The following might be considered:

*Clarification of the role, responsibilities and authority of the Medical Disciplinary Board.* Specifically, the Board, rather than the Director of the Department, should be empowered to select and retain the medical coordinator and investigators assigned to medical complaints.

*Affirmation of the responsibility of the Board's independent legal counsel* to assist the Board and medical coordinator in analyzing cases, drafting rules and providing technical assistance. A key role of the counsel would be to advise the Board on legal matters during disciplinary hearings. The hearing process should be refined to allow identification of cases warranting further



investigation or disciplinary action. Complaints with no merit as determined by the Board can then be closed in a timely manner.

*Retention by the Board of an executive director* to coordinate activities of the Board, investigators, attorneys, the medical coordinator, the Department director and other appropriate Department staff. The executive director also could be made responsible for reporting Board actions to hospitals, professional associations and other state and federal agencies.

Adequate funding should be available to implement these revisions since the law earmarks physician licensure fees to finance the disciplinary mechanism. We understand that a surplus currently exists in the Medical Discipline Fund which could be used to carry out the suggested modifications.

### **Mandatory Reporting**

The Society is offering to the General Assembly legislation which would require the reporting of final actions taken against individuals licensed under the Medical Practice Act. The intention of mandatory reporting is to enable the Medical Disciplinary Board to be in a better position to discharge its obligation to assure adequate protection of the public. Mandatory reporting calls for certain individuals, agencies, health facilities and other groups to report to the Board various final determinations dealing with disciplinary matters regarding any licensed physician.

Under mandatory reporting provisions to be proposed by ISMS, the following bodies would be required to inform the Medical Disciplinary Board of determinations involving physicians:

*Hospitals and other licensed health facilities.* Hospitals would have to report any restrictions or terminations of a physician's privileges based upon a final determination that, in accordance with an institution's by-laws, the physician has either committed an act or acts which may constitute unprofessional conduct or may be mentally or physically disabled. Also to be reported are voluntary terminations or restrictions of a physician's clinical privileges taken in lieu of formal actions.

*Professional liability insurance companies.* Insurers would have to furnish a report of all malpractice settlements.

*Professional Associations.* Organizations such as the Illinois State Medical Society and the American Medical Association would have to report final determinations

of pertinent unprofessional conduct or a physician's inability to practice with reasonable skill and safety to patients.

*Courts.* Courts would report all felony convictions involving physicians and all malpractice awards to the Board.

*State Agencies.* Other state agencies dealing with physicians (*i.e.*, Public Aid, Public Health, Dangerous Drugs Commission, Law Enforcement) would be required to report final actions taken against physicians.

All reports would have to be forwarded to the Medical Disciplinary Board as soon as possible, but no later than 60 days after a final determination is made. Specifically, the Board would be informed in writing of the individual physician involved, the determination made and any other pertinent information.

Failure to report as required would be considered a misdemeanor. Anyone who, in good faith, provides a report or other information to the Board, assists in the investigation or preparation of such information, or participates in a proceeding—including members of the Disciplinary Board—will be immune from civil or criminal liability, except for wilful or wanton misconduct. Individuals reporting to hospital or other peer review committees would continue to receive similar protection under existing law.

The Medical Disciplinary Board would be required to obtain and maintain reports on physicians licensed in the state who have been involved in disciplinary or court actions. We would hope that complaints alleging physician misconduct received from medical society committees or hospitals would receive expedient consideration.

A physician who is the subject of a complaint would have to be notified by the Board within 30 days of any report being received. The physician would have the right to examine the file kept by the Board and include a statement indicating the correctness of the material on file. The physician also would retain the existing right, through court action, to have any information in the file amended or expunged.

Final actions taken by the Disciplinary Board would have to be reported to the following within 30 days: (1) hospitals or other facilities; (2) professional associations; (3) professional liability insurers; (4) the Federation of State Medical Licensing Boards; and (5) the individual filing a report and the original complaining party.

Mr. Chairman, that concludes our testimony. I would be happy to respond to any questions that you or other members of the committee may have. ◀

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# Special Articles

## What the Physician Should Learn As Opposed To How the Physician Should Learn

BY HOWARD S. BARROWS, M.D./SPRINGFIELD

*Presented at the Ninth Illinois Congress on Continuing Medical Education, Oak Brook, Illinois, September 11, 1981*

This paper will consider *how* the physician should learn in continuing medical education in addition to the usual considerations of *what* he should learn. To develop this point, I will review how the physician thinks and how the information the physician uses in his evaluation and care of patients was acquired. Then I will attempt to show how this information should affect the design of your course in continuing medical education. In

the process of doing this I will describe the interrelationship of scientific thinking and information recalled from memory in providing care to the patient. All this will lead to the important difference between educational and behavioral objectives. Behavioral objectives will underline the important role of simulations in physician learning. Lastly, I will try to convince you that work with patient problems not only provides appropriate learning for physicians, but helps them to recognize their real learning needs, allowing continuing education to be tailored to the individual learner.

It is my impression that most CME courses are designed around *what* the physician should learn. Course objectives are defined in terms of content. This might include introduction of new concepts in treatment or diagnosis, or a review or update of important facts about a group of problems or diseases. Topics might seek to expand the awareness of new knowledge in medicine or related areas of medicine as the social, ethical, legal or psychological concepts of practice.

A few CME courses are aimed at skill acquisition. These are "how to" courses in special surgical techniques, cardiopulmonary resuscitation, medical photography, hypnosis, acupuncture and counseling. In all of these, it is usually the edu-

**HOWARD S. BARROWS, M.D.**, is a board certified neurologist affiliated with the SIU School of Medicine, Springfield. Associate Dean for Educational Affairs and Professor of Medicine for SIU, Dr. Barrows is also certified by the Royal College of Physicians and Surgeons of Canada. Dr. Barrows holds numerous editorial and professional positions, including chairmanship of the American Academy of Neurology Subcommittee on Evaluation of Continuing Education.



cational goals that are considered, *what* the physician should learn. Few ever consider *how* the physician should learn.

There are many ways to teach or learn. Choice of method depends upon how the knowledge is to be learned. For example, let us suppose that your CME course will review or update the physician's knowledge about Italian Somaliland Camel-Bite Fever. What teaching-learning method will you use? While you are thinking about the design of a CME course concerning this well-known entity, let me in turn give you a review or update of your knowledge in an area relevant to this discussion. This area needs to be understood before we continue our discussion of alternative teaching-learning methods.

### The Cognitive Process

How does the physician problem solve, reason, think or whatever you want to label his cognitive processes in evaluating and caring for patients? How does he access and use the medical knowledge held in long term memory in direct patient care? How was this knowledge acquired? After almost a decade of fruitful research into the cognitive processes of the physician, better answers to these questions are possible. Unfortunately, many responsible for the education of medical students and physicians still seem unaware of this information or its significance. In fact, many faculty lose sight of the fact that medicine is not a natural science concerned with (in the words of Herbert Simon) how things are. Medicine is an applied science concerned with how things should be. The important ability of the physician is not his possession of medical knowledge. It is his ability to *use* that knowledge to improve or maintain the patient's health. Confucius said this 2500 years or so ago, "The essence of knowledge is in its use."

Our task as educators is to better prepare the physician to effectively translate medical knowledge into patient care. Therefore, let me give you a brief review of our present understanding of how the physician reasons. When first confronted by the patient, the physician almost immediately develops multiple diagnostic hypotheses for the patient's problem or complaint. Although all physicians do this, it is surprising how many are almost consciously unaware of the phenomenon. The sequence of questions asked and examinations performed on the patient are strategically and efficiently designed to see which hypotheses can be further supported or weakened.

As he proceeds, the physician also begins to contemplate treatment options. The process con-

tinues often requiring the generation of new hypotheses and the employment of new inquiry strategies until the physician is satisfied that the patient picture he has assembled from the important facts in his inquiry fits well enough into one of his diagnostic hypotheses that he can decide on diagnosis and treatment. This is a very brief review that ignores many details and other fascinating and important cognitive events. Nevertheless, it serves to show you that the physician uses a multiple hypothetical, deductive process in his reasoning.

In "Broca's Brain" Carl Sagan said, "If you spend any time spinning hypotheses, checking to see whether they make sense, whether they conform to what else we know, thinking of tests you compose to substantiate or deflate your hypotheses, you will find yourself doing science. . . ." The parallel is obvious. This is the scientific method of clinical practice. The effectiveness of the physician's care is dependent on *both* the effectiveness of reasoning ability and the information he can recall and bring to bear on patient care problems. Can good hypotheses be recalled to provide possible alternative causes for the problem? Can appropriate inquiry strategies be recalled from prior patient experiences to choose the questions and examinations that will help select the more likely hypotheses? Can important principles or concepts of basic or medical science be recalled to create new strategies, questions, physical examination items, tests that can better separate competing hypotheses? Can data about treatments and tests; their sensitivity, specificity, reliability, risk, and effectiveness be recalled to make appropriate treatment decisions?

We often see competent physicians, especially those very experienced in a particular area, come to accurate conclusions with very few inquiries. They seemingly use a different method of problem solving from the model just described. On closer examination, this is not the case. The difference is their ability to immediately recall appropriate hypotheses from the presenting problem, recall sophisticated inquiry strategies that will knife into the patient problem quickly, and recall prior decisions that have paid off in many previous patients. The process, as described, is intact but abbreviated. If such a physician is presented with a patient problem in an area in which he has had little experience you would see the model described for this process blossom out in its fullness. The effective evaluation and care of patients depends upon both the adequacy of recallable knowledge and the ability to use that knowledge by means of a logical, scientific problem solving process. Effective care cannot be accomplished



by knowledge alone. I am sure you have all seen physicians who have encyclopedic knowledge, but are atrocious in their care of patients. Like the “muscle-bound” athlete they are “knowledge bound.” It is amazing how far one can go with a limited knowledge base by employing good problem solving or scientific reasoning. It is the combination of both that is crucial. We need to fully understand this scientific process of the physician if learning is to truly meet the physician’s needs.

### Knowledge Acquisition

In this side path we took before selecting the appropriate method for teaching a course in Italian Somaliland Camel-Bite Fever, the second question concerned how this knowledge that the physician recalls and uses in his reasoning was acquired. Studies suggest that almost all of the information recalled in the clinical encounter was obtained from active work with prior patient problems. Information learned from previous patients in terms of outcome, ultimate diagnosis, pathology, test results, related literature review, conversations and consultations with specialists or colleagues. This seems to be unforgettable information in working with a patient.

You must realize that information actively acquired in the clinical encounter is not readily recalled outside that context. I would not be prepared to give a lecture on cerebral vascular disease at this moment. If I were to sit and try to recall all of the information in my memory to present this topic, it would not come to mind because it was not acquired that way. I cannot tell you what inadequacies there are in my knowledge or skills in working with cerebral vascular disease either. To give the lecture I would have to review textbooks to stimulate and organize my thoughts.

However, should I be confronted in the next few moments with any variety of patients with cerebral vascular disease, all kinds of appropriate information would pop into mind as the patients began to unfold their problems. This is true of all clinicians. Most useable and remembered information is acquired in the clinical work situation. Educators have constantly reminded us that the most effective learning is that which occurs in the real or simulated task situation. The commercial airline pilot’s skill is based on hours of learning in both real flight and sophisticated, expensive simulations, not on lectures or readings alone,—and we are thankful for that!

### In Context

Cognitive psychologists tell us that our memory

banks associate facts in the context of the learning situation. If information is learned in a course on a particular subject, then it is associated with other facts about the subject and recalled when that subject is discussed. If those facts are not used soon, much will decay.

There are two basic ways to memorize. One is to repeat information again and again, like trying to remember a telephone number: this method also has limited time for effective recall unless the information is instantly used and reused. The other method is to use the newly acquired facts to elaborate and modify what is already remembered or understood. In summary, learning facts in the context of work with a patient’s problem increases the likelihood that they will be recalled again when working with another patient problem. Facts learned within the context of a course on a particular subject may not be recalled in a patient situation even when they may be relevant. If you think about this, it has been demonstrated to you many times in the past. “Damn it, I knew that, how come I didn’t think of it!” Formal studies of physicians and students have shown this to be true.

Now let’s return to Italian Somaliland Camel-Bite Fever. What would be your reasons to give such a course to physicians? Would you like to prepare them for medical rounds or conversations with colleagues where they might be asked “What do you know about Italian Somaliland Camel-Bite Fever?” Would you like to prepare them for a certification examination of one type or another, FLEX or National Boards, written examinations, specialty board or recertification examinations? Examinations have scorable objective questions where you might want the physician to recognize the right alternative and score well. If your real objective for putting on such a course was either of these, then certainly the best teaching-learning method would be to give participants flash cards to work with, a written text to review, or review articles in the literature they might look at and memorize. Perhaps your reason for putting on this course would be to impress the participants with how much you know about Italian Somaliland Camel-Bite Fever so that they will send you referrals whenever this condition is suspected or diagnosed. I’m sure this is a frequent, if not tacit, objective. Perhaps your objective is to make the physicians aware of Italian Somaliland Camel-Bite Fever so that if they are interested they might study more about it later because, as a consequence of taking your course, they now realize the importance or fascination of this condition. I often feel that this is also a common objective

of many CME courses and is probably legitimate, but should be stated upfront. If not those two, perhaps your objective is to give the physicians "up-to-date" information about the latest hot research on Italian Somaliland Camel-Bite Fever. If any of these last three are your real objectives, then by all means the method is to give stimulating lectures and a reprint list or text to take away. If you only have an hour or so for your CME course, which is often the case, these last three are the only possible objectives.

### **Patient Care Knowledge**

In many instances, the real objective of a continuing medical education course is to facilitate the physician's ability to recognize that patients with certain complaints or presenting problems may have a particular condition or disease; in this instance, Italian Somaliland Camel-Bite Fever. A related objective is that the physician should be able to establish the diagnosis, once suspected, by appropriate questions, items on the physical examination and laboratory tests. A third closely related objective is that with a known case of the disease, Italian Somaliland Camel-Bite Fever, the physician should be able to treat it appropriately. If your objectives are any or all of these, then you intend that as a consequence of taking your continuing medical education course, the physician will be better able to deliver patient care. The physician must be actively involved in the learning process if he is to deposit the information about Italian Somaliland Camel-Bite Fever into his long term memory banks in a way useful to his clinical work. He needs to work with patients that feature Italian Somaliland Camel-Bite Fever or conditions that may mimic it. If you want him to use appropriate inquiry strategies, generate appropriate hypotheses, and make good decisions in dealing with this entity, he must learn *how* to do this in work with patient problems. In most instances, patients are not readily available, particularly in large numbers, for continuing education of physicians. In addition, even if they were available, such educational use would often be detrimental to their care.

Ironically, patients may have limited educational value. They have many unknown variables and the particular challenge they offer cannot be selected. A variety of simulations can be used that will challenge the physician equally well to reason through appropriate problems and to acquire and apply new knowledge in patient evaluation and care. Simulated patients, computer simulations, a variety of printed simulations such as Problem Based Learning Modules or Patient Management Problems will allow you to use a

teaching tool that is aimed at learning objectives related to the impact of continuing education on the physician's ability to care for people. You could choose problems that would offer the clinical challenges related to your goals, challenges in disease recognition, diagnosis and treatment. Use of simulations, of course, is not revolutionary. It has been used for many years in law, aviation, astronautics, supertanker navigation, locomotive control, business schools, mathematics and physics, as a small sample.

An added advantage to this approach is that the physician involved in a patient problem will recognize what he already knows well, and therefore doesn't need to learn, and what he really doesn't know and realizes he must learn. It is hard for any of us to know exactly what we need to learn in continuing education. As I mentioned before, our information about medicine is not stored away in terms of subject areas. Our knowledge or lack of knowledge about things becomes apparent only when we begin working with patient problems. At the CME level of education, no two students are alike. All physicians have had different educations and personal experiences with patients. You cannot give them all the same dose of education to treat their ignorance any more than you would give all epileptics the same dose of the same anticonvulsant to treat their seizures. The educational approach must be individualized. By working with patient problems in the area of your subject matter, in this case Italian Somaliland Camel-Bite Fever, the physician will clearly see what information he needs to learn.

The key to determining *how* the physician learns as opposed to *what* he learns is to identify your real objectives for the physicians in your course. This should mean what they will be able to do as a consequence of taking the course, rather than what you would like to teach. Objectives stated in this manner are called in "behavioral" objectives in educational jargon. The next time you plan a CME course, think in terms of these objectives. Why are you offering this course? What will it do for the participant? What should he be able to do that he was not able to do before, as a consequence of taking the course? With these objectives you can choose *how* the physician is to learn—sensitive to how the physician needs to store the information in his memory if it is to work for him and sensitive to how you can help the physician to develop better problem-solving or reasoning skills with the information you plan to offer.

Some medical schools are beginning to adopt what is called the problem based, self-directed method of learning. The students are presented



with a series of patient problems to work through with the information they have. These problems allow the student to realize what they need to learn, both in the basic and clinical sciences. At the same time, they develop the skills necessary to obtain that information in the most efficient and effective manner. This prepares them well for their future tasks. Patient problems will always be presented to them as unknown, they should always ask themselves what more they need to learn, and have the skills to learn it.

### Evaluation

The use of behavioral objectives changes the way in which you have to evaluate your course. If you want to improve the physician's ability to recognize, establish the diagnosis and treat, then a questionnaire asking him at the conclusion how he liked the course doesn't touch upon these objectives. You have to measure whether, as a consequence of taking your course the physician can, when confronted by a patient problem, recognize, diagnose or treat Italian Somaliland Camel-Bite Fever more effectively. Even better, you should be able to evaluate whether the physician actually does better in his own practice, not just in a testing

situation. The first tests clinical competence, what the physician can do under observation. The second tests performance, what he actually does in his practice. We now have the tools and ability to do this in a scientific, valid and reliable way.

### Conclusion

This article sought to stress the need to consider *how* the physician should learn, as well as *why*. We reviewed the clinical scientific method of the physician and what is known about how he acquired the information he uses in his practice. This review was done to stress the learning methods that would be important in physician education, depending on educational goals.

Goals, in this light, must be behaviorally stated to stress the "how" of education as opposed to the "what." The appropriate choice of teaching-learning method to match the real behavioral objectives of a course in CME was also touched upon. A problem-based approach not only facilitates learning but also stresses what needs to be learned by the individual physician. Lastly, we cannot overemphasize the importance of matching evaluation methods to behavioral objectives. ◀

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## Obituaries

**\*Bernstein, Arthur**, Chicago, died June 25, 1982 at the age of 73. Dr. Bernstein was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

**\*Koptik, George**, Niles, died June 29, 1982 at the age of 57. Dr. Koptik was a 1949 graduate of Northwestern University Medical School, Chicago.

**Mitchell, Oliver L.**, Antioch, died June 29, 1982 at the age of 77. Dr. Mitchell practiced medicine in Chicago for 33 years.

**\*Rafool, Francis P.**, Peoria, died June 21, 1982 at the age of 63. Dr. Rafool was a 1944 graduate of Northwestern University Medical School, Chicago.

**\*\*Rhodes, Julius**, Lincolnwood, died July 2, 1982 at the age of 86. Dr. Rhodes was a 1922 graduate of the University of Illinois College of Medicine, Chicago.

**Siber, Max**, Skokie, died June 8, 1982 at the age of 65.

**\*Simpson, Frederick**, Boca Raton, Florida, died June 21, 1982 at the age of 69. Dr. Simpson was a 1939 graduate of the University of Illinois College of Medicine, Chicago.

**\*\*Sutton, Robert M.**, Peoria, died June 26, 1982 at the age of 84. Dr. Sutton was a 1924 graduate of Harvard Medical School, Boston.

**\*Tito, James V.**, Des Plaines, died June 28, 1982 at the age of 71. Dr. Tito was a 1937 graduate of the University of Health Sciences, Chicago Medical School.

**\*\*Williams, C.H.**, West Frankfort, died June 7, 1982 at the age of 87. Dr. Williams was a 1920 graduate of Rush Medical College, Chicago.

**\*Wright, Marcellus P.**, Las Cruces, New Mexico, died April 2, 1982 at the age of 68. Dr. Wright was a 1949 graduate of University of Health Sciences, Chicago Medical School.

*\*Indicates ISMS Member*

*\*Indicates member of ISMS Fifty-Year Club.*

## Immunization Requirements Under School Code Regulations

In the past two years the immunization level of Illinois school children has climbed dramatically to exceed a 90% rate of compliance. The incidence of measles was lower in calendar year 1981 in Illinois than ever before. Improvement followed renewed enforcement of requirements for immunization of children attending primary and secondary schools as mandated under Illinois law. Good enforcement requires clear, specific and consistent understanding and adherence by physicians, parents, and school personnel.

The requirements are stated definitively in regulations promulgated under Paragraph 27-8.1, Chapter 122, Illinois Revised Statutes, the School Code of Illinois. The purpose of this article is to answer some of the questions most often asked about them.

Illinois law is consistent with recommendations of the American Academy of Pediatrics' Committee on Infectious Diseases and the Public Health Service Advisory Committee on Immunization Practices. The regulations specify (1) what deviations from the recommended schedules are permitted and (2) what documentation is necessary to assure that a child has had the immunizations. The accompanying table summarizes these specifications.

*Note particularly:* (1) A note from the doctor stating that no repetition is necessary will be accepted if measles vaccine was given on or after the first birthday. The evidence is strong that measles vaccine is less effective if given too early. To avoid uncontrollably weakening the requirement, a rigid cutoff age is necessary. (2) Month, day and year that vaccinations were given must be specified when—but only when—the month and year alone would not show whether the child's age or the interval between immunizations of a series was adequate. (3) A child who has started the OPV and the DPT or Td series may be admitted to school provided he has appointments to complete the series at the recommended intervals. (4) A physician's statement specifying a medical contraindication in a child may be substituted for any immunization. The parent's statement of religious objections to immunizations may also be accepted.

Most questions about the requirements will be answered by the chart on the following page. For those questions that it does not answer, physicians are invited to call their local health department or the Illinois Department of Public Health Immunization Program at 217/785-1455.



# What the School Staff Will Look for in Your Patient's Immunization Record

Child's Classification	DPT and Td	OPV	Measles	Rubella
<b>Protected and in Compliance</b>	<i>Under 6 years of age:</i> 3 or more doses of DPT, at least 4 weeks apart, and another after 6 months or longer. If child is entering grade K or 1, the last dose must have been given on or after the 4th birthday. *	2 or more doses OPV, at least 6 weeks apart, and another after 8 months or longer.	Measles vaccine at age 15 months or later (1st birthday or later with the doctor's note), (Specify live virus vaccine if given before 1968)	Rubella vaccine on or after the first birthday  or Antibody titer.
	<i>6 years or older:</i> 2 or more doses DPT or Td, at least 4 weeks apart, and another after 6 months or longer. Another dose of Td is needed if 10 years have passed since the last dose.	If child is entering grade K or 1, the last dose must have been given on or after the 4th birthday. *	Physician's statement that child has had the disease  or Antibody titer.	
<b>Unprotected But in Compliance</b>	Not fulfilling the above, but, for any immunizations lacking, showing: Doctor's or clinic appointments to receive remaining OPV and DPT or Td dose(s) as soon as medically indicated.  or Physician's statement of specific medical contraindications;  or Parent's or guardian's statement of religious objections			
<b>Dating Immunizations</b>	Date of each immunization must be given as month, day, and year <i>unless</i> the year or month and year alone shows that it was given after the minimum interval or age required.			
<b>*Physician Certification Statement</b>	Where different OPV or DPT schedule was used or medical records are not available, a physician may certify in writing that he believes the child is protected. The physician's statement for certification must include what is known of the child's immunization history, including any dates available. School district will forward statement for IDPH medical review.			

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Virgil Williams, M.D.

*Examination by appointment.*



# Viewbox

(Continued from page 77)

## Diagnosis: Non-Hodgkin Lymphoma

*Patient 1:* The large irregular duodenal ulcer in Figure 1 extends into a lymphomatous mass identified by computed tomography (arrows) in Figure 4. An ulcer in the second or third part of the duodenum in the absence of Zollinger-Ellison syndrome should be considered neoplastic.

*Patient 2:* Bowel loops are spread apart and irregularly narrowed and there are scattered nodules and thick irregular mucosal folds in addition to the ulcer (arrows) in Figure 2. This type of ulcer could be found in a smooth muscle tumor but the diffuse findings would not be present.

*Patient 3:* The rectum and cecum are the most common sites for lymphoma.

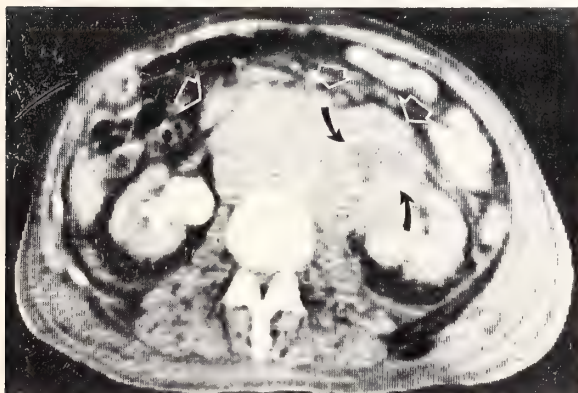


Figure 4

C.T. of Patient 1. There is a large lymphomatous mass surrounding the vena cava and calcified aorta (white arrows). The ulcer (black arrow) retains some contrast material.

## Gastrointestinal Non-Hodgkin Lymphoma

(Continued from July issue)

### Small Intestine

Lymphoma constitutes about 20% of all malignant tumors of the small intestine. The terminal ileum is the most common site of involvement. Multiple sites of involvement are common. The radiologic appearance of lymphoma involving the small intestine can be divided into five groups.<sup>1,2</sup>

(1) *Nodular.* There are multiple intramural or intraluminal filling defects (Figure 5). There may be central ulcerations of nodules. The nodules may be diffuse and small (a few mm in diameter)

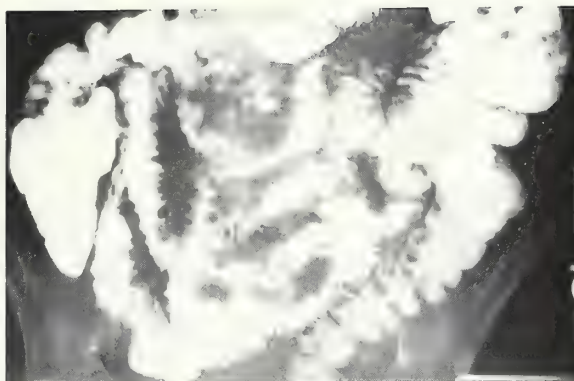


Figure 5

Lymphoma of the third part of the duodenum with narrowing, disrupted mucosa, and nodules (bracket).

and often involve long segments of bowel. In some cases, nodules may be larger and less numerous. These larger nodules can be a leading point for intussusception.

(2) *Infiltrative.* The bowel wall becomes infiltrated and thickened. The length of bowel involved is variable. Alternating areas of narrowing and dilation are common (Figure 2). There is frequent straightening and separation of bowel loops due to thickening of the bowel wall. The mucosal folds may be prominent (Figure 6). A characteristic late finding in infiltrating lymphoma is "aneurysmal" dilation (Figures 1,2). The affected segment of small bowel becomes dilated because of destruction of bowel wall and neurentic plexes with absence of secondary fibrosis. Marked rigidity and obstruction are uncommon. When obstruction does occur, it is usually the result of ulceration and infection causing fibrosis.



**Figure 6**

**Lymphoma with diffuse thickening, nodules, and spreading of bowel loops.**

(3) *Polypoid*. A large intraluminal mass without significant intramural involvement. These patients can also present with an intussusception.

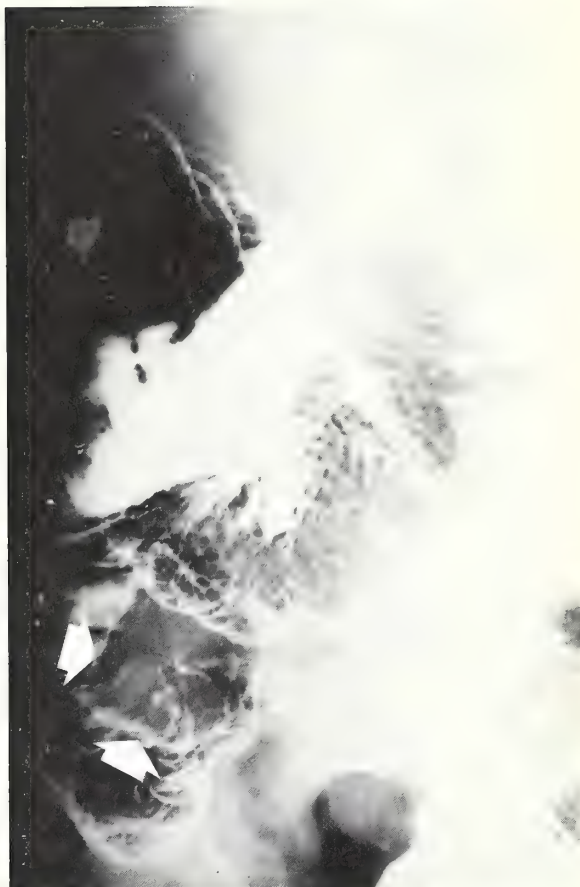
(4) *Endoexocentric*. A large irregular ulceration with multiple fistulae communicating with the adjacent bowel. The irregular ulceration represents an excavation within a large tumor mass. The mass is indicated by displacement of adjacent bowel loops.

(5) *Mesenteric*. Generalized dilation of bowel is common. Large extraluminal masses displace visceral organs. There is associated invasion of the small intestinal wall, but the involved loops are not fixed, angulated or obstructed in contrast to abdominal carcinomatosis. Diffusely dilated small intestinal loops may be associated with segmentation of the barium column identical to sprue. The intestinal folds, however, are often thickened or nodular.

Primary small bowel lymphoma can mimic a large number of diseases including: regional enteritis, lymphangiectasia, eosinophilic enteritis, tuberculosis, histoplasmosis, giardiasis, carcinomatosis, celiac disease and Whipple disease as well as other causes of malabsorption syndrome.

## Colon

Primary lymphoma of the colon constitutes less than 1% of all colonic malignancies. O'Connell and Thompson<sup>3</sup> classified primary lymphoma of the colon using a scheme similar to the one used for small intestinal lymphoma. It was noted that a polypoid intraluminal mass was present in 7/13 patients. In all seven of these patients the mass was in the cecum.<sup>4</sup> The remaining six patients had nodular, infiltrative and mesenteric forms of disease with radiographic appearances



**Figure 7**

**Diffuse small nodules of the colon plus a cecal mass (arrows). Biopsies proved these nodules to be lymphocytic lymphoma. (Courtesy of Dr. M. VanDrunen, V.A. Hospital, Hines, IL)**

similar to those found in the small intestine.

The cecum and rectum are the most common sites reported. While cecal lesions are often large and polypoid (Figures 3,7) they may also be identical to annular adenocarcinoma. Rarely there may be numerous tumor nodules throughout the colon (Figure 7). The differential diagnosis of primary lymphoma of the large bowel includes: adenocarcinoma, amoebiasis, schistosomiasis, tuberculosis, actinomycosis, regional enteritis, ulcerative colitis and even pseudomembranous colitis.

## Treatment

Treatment and prognosis of primary gastrointestinal lymphoma depends on the stage of the



disease. Computed tomography is valuable for staging, therapy planning, and followup after therapy. Approaches to therapy have been summarized in a recent clinical conference.<sup>6</sup> Stage I<sub>E</sub> lymphoma is usually resected to make the diagnosis. Radical surgery is not necessary, but postoperative radiotherapy is strongly recommended.

For Stage II<sub>E</sub> disease, chemotherapy is combined with radiotherapy. Patients with Stage III<sub>E</sub> or IV disease are primarily managed with chemotherapy. Radiation is only used for serious local problems.

There are two principle areas of controversy regarding treatment. Some advocate a more aggressive surgical approach with resection of Stage I<sub>E</sub> and II<sub>E</sub> lesions as well as palliative resection of more advanced lesions to avoid hemorrhage and perforation associated with aggressive chemotherapy. The second controversy involves the increased incidences of second malignancies in patients who receive combined radiotherapy and vigorous chemotherapy.<sup>6</sup>

## Prognosis

Statistics regarding prognosis are difficult to evaluate due to non-standard staging, differences in treatment and differing patient populations. The data from several large series,<sup>(5-8)</sup> especially one in which prognostic factors were carefully analyzed,<sup>9</sup> allows a few general statements.

The most important single prognostic factor is the stage of the disease. The five year survival rate was approximately 70% for Stage I<sub>E</sub>, 40% for Stage II<sub>E</sub> and zero for Stages III<sub>E</sub> and IV. The previously described subdivision of Stage II<sub>E</sub> into II<sub>1E</sub> and II<sub>2E</sub> appeared to have prognostic value. Five year survival rate for Stage II<sub>1E</sub> (only regional nodes involved) was approximately 60% but was zero for Stage II<sub>2E</sub> (noncontiguous nodes involved).

Within Stage I and II disease, the size of the primary lesion also had prognostic value. Lesions less than 5cm in diameter had an 80% five year survival while those greater than 5cm had a 40% survival. Gastric lymphomas have the best prognosis. In one series of 112 patients with gastrointestinal lymphoma, 50% were Stage III<sub>E</sub> at time of discovery, while 37% were Stage I<sub>E</sub> and 13% Stage II<sub>E</sub>. It is noteworthy, however, that 47% of primary gastric lymphomas were Stage I<sub>E</sub> at the time of discovery.<sup>5</sup> This is probably related to the fact that gastric lesions are discovered at an earlier stage.

Histology of the neoplasm does not appear to

affect prognosis as much as the other factors, but diffuse histiocytic lymphoma has a worse prognosis in most series. A high index of suspicion is necessary to diagnose this potentially curable malignancy as early as possible.

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## THE PROBLEM

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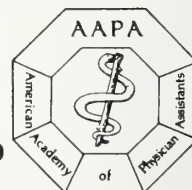
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# Abstracts of Board Actions

*(Continued from page 83)*

## **MEDICAID**

Based upon extensive review by the Third Party Payment Processes Committee, the Board approved a position paper on restructuring of Medicaid and authorized the use of the ISMS position paper and the Chicago Medical Society plan in negotiation with the Department of Public Aid and the Governor's office.

Related to this, the Board reviewed proposed changes in Medical Assistance Program coverage and approved, with some exceptions, the following elements as developed by Public Aid: (1) true emergency room visits; (2) pharmacy services; (3) medical supplies and equipment; (4) optical and podiatric services/supplies. Action was withheld on proposed changes in coverage for outpatient hospital visits. No action was taken regarding other aspects of proposed changes in the program.

## **ISMS POLICIES**

Acting upon a report of the Policy Committee, and in keeping with actions of the House of Delegates, the Board approved policy statements for inclusion in the Policy Manual, on the following items:

- Informed Consent (Subst. Res. 13, I-81)
- Health Planning (Res. 25 and 37, A-82)
- Medical Education-Schools (Res. 21 and 22, A-82)
- Workers Compensation (Res. 32, A-82)
- Health Insurance, Voluntary Plans (Res. 9 and 33, A-82)
- Reimbursement for Ambulatory Services (Res. 34, A-82)
- Tobacco Farm Subsidies (Res. 2, A-82)
- Firearms (Res. 31, A-82)
- Drugs, Prescriptions (Res. 36, A-82)
- Motorcycle Helmets (Res. 28, A-82)
- Abuse and Neglect of the Elderly (Res. 35, A-82)

In addition, based upon House action, the Board asked that a clarifying resolution regarding automobile seatbelt use be developed for the next meeting of the House. Procedures for legal counsel review of House action, (Res. 11, A-82) was referred to the Committee on Constitution and Bylaws.

## **ISMS EDUCATIONAL & SCIENTIFIC FOUNDATION**

It was reported that a fund for medical students has been established in the Educational & Scientific Foundation (ESF). This will support activities of the Task Force on Financial Aid to Medical Students. To date, initial contributions have been received in the amount of about \$107,000.

## **DRUGS & THERAPEUTICS**

The Board approved that the following drugs be included in the IDPA Drug Manual: Tenormin, Desyrel, Calan, Isonitin, Feldene, Indocin-SR, Enduron, Magnesium Salicylate, Lopid, and the entire potassium group listed generically. The Board also accepted a recommendation that a series of drugs be removed from the Drug Manual.

## **MIGRANT HEALTH**

Acting on recommendations of the Council on Medical Services the Board voted to participate with the Illinois Migrant Council and IDPH in a U.S. Department of HHS grant, to: (1) Develop physician educational programs and materials; (2) Coordinate local medical resources, through county medical societies, when possible; (3) Assist IDPH in further development of residency programs in geographic areas appropriate for the care of migrant workers; and (4) Coordinate medical student activities in screening programs.



## TRAVEL PROGRAMS

The Board approved six travel programs offered by INTRAV, including: Caribbean Air/Sea Cruise; Dutch Waterways; Orient Express, Main River Cruise; Canadian Rockies and Greek Isles. A seventh program offered by Schaumburg Travel to Spain/Portugal, also was approved.

## FUTURE MEETINGS SCHEDULE

After review of available dates and hotel facilities the Board adopted the following 1983 meeting schedule:

### House of Delegates

April 22-24	Palmer House, Chicago	Annual Meeting
November 12-13	Holiday Inn, Decatur	Interim Meeting

### Board of Trustees

January 29-30	Palmer House, Chicago
April 21-24	Palmer House, Chicago
June 23-24	Hotel accommodations based on availability
September 24-25	Palmer House, Chicago
November 11-13	Holiday Inn, Decatur

The Board approved an interim meeting, November 13-14, 1982, at the Sheraton, St. Louis. Additionally, related educational programs will be held in conjunction with the meeting.

## NOMINATIONS AND APPOINTMENTS

The Board approved:

- Appointment of ISMS members to one-year terms on the Society's councils and committees for 1982-83. Council chairmen appointed were: Drs. Robert P. Johnson, Springfield, Affiliate Societies; Ronald G. Welch, Belleville, Economics; Boyd McCracken, Greenville, Education and Manpower; P. John Seward, Rockford, Governmental Affairs; Morgan Meyer, Lombard, Medical-Legal; Wallace Berkowitz, Belleville, Medical Services; Douglas Bey, Normal, Mental Health and Addiction; and Leo Wrona, Joliet, Public Relations and Membership Services. Appointed chairman of those committees reporting directly to the Board were: Drs. Robert A. Behmer, Rockford, CME Accreditation; Joseph H. Skom, Chicago, Drugs and Therapeutics; Andrew Brislen, Chicago, Health Data; Samuel L. Andelman, Chicago, Health Planning; Gerald S. Modjeska, Chicago, Insurance; George J. Gertz, Chicago, Peer Review Appeals; Cyril C. Wiggishoff, Chicago, Building; and Fred Z. White, Chillicothe, Task Force on Financial Aid to Medical Students.
- Nomination of Drs. Robert C. Hamilton and Eli Borkon to the Illinois Medical Disciplinary Board; and Drs. Alex Spadoni and Joseph Winterhalter to the IDPH Medical Determinations Board.
- Appointment of Ad Hoc Committee on Adjusting Downstate Trustee Districts' Boundaries as directed by Resolution 16 (A-82), made up of the 3 immediate past presidents (Drs. White, Browns, Seward) and Dr. John Ring, Mundelein.
- Nomination of Drs. Eugene Diamond, Chicago, and Edward DuVivier, Alton, for appointment to the IDPH School Health Advisory Committee.

## OTHER MATTERS

In other actions, the Board:

- Approved a pricing schedule for the Society mailing list, for internal or sponsored-program use only.
- Authorized the Council on Medical Services and the Governmental Affairs Council to develop legislation designed to repeal the Laetrile law for Board of Trustees' approval.

- Directed the Council on Education and Manpower to schedule a Symposium on Allied Health Professionals at the 1982 Interim Meeting.
- Further directed the Council on Education to register three representatives for the annual AMA Conference on CME to be held in Chicago on October 1-2, 1982. They are: Dr. Lawrence Hirsch, Council on Education and Manpower; Dr. Robert Behmer, ICCME; and Thomas Pearson, ISMS staff.
- Acting on an ICCME recommendation, approved an increase in Surveyor honorarium from \$100 to \$250, effective April 30, 1982.
- Elected to discontinue staffing and related activities currently being provided to the Physicians Assistants as of December 31, 1982.
- Authorized amendments to the ISMS-sponsored Member Stein-Roe-Farnham Tax-Qualified Retirement Program, to conform with ERISA requirements.
- Directed the Committee on Third Party Payment Processes to develop a mechanism for dealing with member problems regarding "hold harmless" clauses in commercial health insurance policies.
- Authorized a \$350 allocation from the Educational and Scientific Foundation for the purchase of a physician's bag for use at ISMS meetings, and that the Council on Medical Services determine contents and maintenance.
- Approved a reception, in cooperation with the Rehabilitation Institute of Chicago, to provide the Governor an opportunity to publicly sign the Child Passenger Restraint Act and recognize organizations supporting the legislative effort.
- Agreed to co-sponsor a seminar with the Chicago Medical School, entitled "The Medical and Legal Aspects of Claims for Neck and Shoulder Pain."
- Authorized a communication to the Director of the Illinois Office of Education requesting a delay in any legislative initiatives to eliminate mandated physical education and health programs until ample opportunity is provided for public comment.

## THE ARMY NEEDS PHYSICIANS PART-TIME.

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# Doctor's News

**PHYSICIANS IN THE NEWS**—Recently elected officers of the Chicago Medical Society are: **Alfred J. Clementi, M.D.**, Palatine, president; **John P. Harrod, Jr., M.D.**, Chicago, president-elect; **Joseph C. Sherrick, M.D.**, Northbrook, treasurer; and **Richard H. Blankshain, M.D.**, Oak Park, secretary. Other officials installed were **Harry A. Springer, M.D.**, Evanston, council chairman and **Harold L. Jensen, M.D.**, Flossmoor, council vice chairman.

**John R. Tobin, M.D., M.S.**, has been appointed dean of Loyola University Stritch School of Medicine. A co-editor of *IMJ's* EKG column, Dr. Tobin is certified by the American Board of Internal Medicine and the subspecialty board of cardiovascular disease and has served as chairman of medicine at Loyola since 1969.

**James R. Webster, Jr., M.D.**, has been named the first Gilbert H. Marquardt Professor of Medicine at Northwestern University.

**Edward L. Applebaum, M.D.**, Glencoe, has been appointed the Francis L. Ledere Professor of Otolaryngology-Head and Neck Surgery at the University of Illinois.

**George H. Pollock, M.D.**, Chicago, has been re-elected treasurer of the American Psychiatric Association.

**Christina Enroth-Cugell, M.D., Ph.D.**, Evanston, will receive the first Ludwig von Sallman Prize in Vision Research at the Fifth International Congress of Eye Research in the Netherlands in October.

**David L. Nahrwold, M.D.**, has been installed as the first Loyal and Edith Davis Professor of Surgery at Northwestern University Medical School. Dr. Nahrwold succeeds **John M. Beal, M.D.**, Chicago, who has been chairman of surgery since 1963. Dr. Beal, editor of *IMJ's* Surgical Ground Rounds column, is chairman of the board of regents and president-elect of the American College of Surgeons. Dr. Beal will continue as the J. Roscoe Miller Distinguished Professor of Medicine at Northwestern.

**AMA CONFERENCE ON THE IMPAIRED PHYSICIAN**—The American Medical Association's Fifth National Conference on the Impaired Physician will be held September 22-25 at the Portland Marriott, Portland, Oregon.

Co-sponsored by the Oregon Medical Association and the Multnomah County Medical Society, the conference will unite experts in the field to discuss responsibilities in caring for disabled doctors.

Topics for discussion will include family, legal, educational and treatment issues; concerns of state licensing boards, various state and county medical society programs for impaired physicians; physician health in a changing society; and the educational system's impact on impairment. For further information contact Jane Coughlin at (312) 751-5109.

**HOUSE OF DELEGATES INTERIM SESSION**—The Illinois State Medical Society House of Delegates Interim Session is scheduled for November 13-14 at the Sheraton Hotel, St. Louis, Missouri. Also planned are associated educational symposia. Resolutions proposed for consideration at the Interim Session must be received in the ISMS headquarters office no later than October 14, 1982. Resolutions which are received by an earlier deadline, September 10, will be published by author and subject only in the Convention Handbook issue of *IMJ*. Further inquiries about the Interim Session House of Delegates should be directed to the ISMS headquarters office.



**FOREIGN PHYSICIAN PROGRAM**—"An English Pronunciation Seminar For Foreign Medical School Graduates" will be held at the AMA headquarters, 535 N. Dearborn St., Chicago on Saturday, October 16.

The one-day seminar, offered by AMA's Department of Physician's Credentials, is designed to help participants improve their spoken communications with patients. Demonstrations and directions on lip, tongue and teeth placement to properly pronounce 41 sounds will be on the agenda, as well as lectures and oral drills for individual students.

The seminar instructors, Robert H. Lang, Ph.D. director of the Cleveland Academy of Medicine and Elizabeth K., Lang, M.A., author of "Improving English Pronunciation," will spend a portion of the day teaching participants how to use the study guide and audio tapes which contain another 47 lessons and 25 hours of study.

Tuition for the Category 1, eight-hour credit course is \$156.00 for members and \$204.00 for non-members (fee includes materials). For more information contact Mr. Gale Jewett, Department of Physician's Credentials, AMA, 535 N. Dearborn St., Chicago, IL 60610, (312) 751-6570.

**TRAVEL INFORMATION**—ISMS is sponsoring a "Viennese Experience" in conjunction with medical seminars being conducted by the American Medical Society of Vienna. The trip will depart September 30, 1982 from Chicago and return on October 9, 1982. The seminars will include hospital & medical administration, laser surgery, forensic medicine and computer medicine. For more information please contact ISMS Travel Department.

**CANCER RESEARCH AWARD**—Bristol-Myers is now accepting nominations for its sixth annual award for distinguished achievement in cancer research. Eleven judges from cancer research centers throughout the United States and from London and Italy will select the winner of the \$50,000 award. Nominations will be accepted from medical schools, free-standing hospitals and cancer research centers until December 15, 1982. Only one application from each institution will be accepted. For further information, contact: Secretary, Awards Committee, Bristol-Myers Company, 345 Park Ave., Room 43-38, New York, N.Y. 10154.

**CME MEDICAL-LEGAL COURSE**—Physicians and allied health personnel, as well as attorneys and insurance representatives, are invited to attend "Medical and Legal Aspects of Claims for Neck and Shoulder Pain," a one day seminar at the Westin Hotel, Chicago, from 8:00 a.m. to 5:00 p.m., Wednesday, October 6. Co-sponsored by the Department of Rehabilitation Medicine, University of Health Sciences/Chicago Medical School and the Illinois State Medical Society, the program is designed to enhance the understanding of medical-legal ramifications of neck and shoulder pain treatment. Course topics include pharmacologic agents in muscular pain, psychiatric and neurologic terminologies in the evaluation and treatment of neck and shoulder pain, and medical-legal problems. Fee for the CME Category 1, eight-hour credit course is \$75.00, which includes a luncheon and handouts. Deadline for advance registration is September 25, 1982. For further information contact Eugene J. Rogers, M.D., The Chicago Medical School, 333 Green Bay Road, North Chicago, IL 60064; (312) 578-3214.

**TEAM PHYSICIAN AWARDS ANNOUNCED**—The Sports Medicine Committee of the Illinois State Medical Society is soliciting nominations for Team Physician Awards. Individuals nominated must be physicians licensed to practice medicine in all of its branches and ISMS members with a minimum of ten years' service on the high school or college level as a team physician. Recommendations may be made by county medical societies, school officials, coaches, parents, or fans. Team Physician Awards will be made annually. Nomination forms are available from the Sports Medicine Committee, ISMS, 55 East Monroe Street, Suite 3510, Chicago, Illinois, 60603.

# IMPAC

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Chicago, Illinois 60603

312/782-1963

**“They that can give essential liberty  
to obtain a little temporary safety  
deserve neither liberty nor safety.”**

**Benjamin Franklin**



# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**CARBONDALE:** Family or General Practice. Community Health Center in southern Illinois, 10 miles from SIU-Carbondale. Affiliation with Black Lung Clinic Programs possible. Established practice with multi-disciplinary staff. Position available immediately. Salary, fringe benefits are very competitive; malpractice insurance and vacation also provided. CONTACT: George M. O'Neill, Shawnee Health Service & Development Corporation, 103 S. Washington, #210, Carbondale 62901 (618-457-3351). (4)

**CENTRAL ILLINOIS:** Two community hospitals within twenty minutes of each other are currently seeking a urologist. Possible partnership with consulting urologist now servicing this area. More patients than one urologist can handle. Area is known for recreational activities. Contact: Search Committee, P.O. Box 430, Pana, 62557. (217-562-2131 x271) (4)

**CLIFTON:** Service Area, 8,500—Immediate opening for family practitioner in rural setting. First year: guarantee, office space/staffing provided. Seventy miles south of Chicago on interstate highway. Excellent school system. Obstetrics or general internal medicine background helpful. CONTACT: George Rasmussen, Central Community Hospital, Clifton 60927. AC 815-694-2392. (10)

**GALESBURG:** Population 35,305. Seat of Knox County, pop. 61,300. An attractive college community 180 miles from Chicago. Near Peoria, Quad-Cities. Diversified industry and agribusiness. Full selection of educational, cultural and recreational activities. For information on practice opportunities, CONTACT: David D. Fleming, Vice-President, Galesburg Cottage Hospital, 695 N. Kellogg St., Galesburg 61401. 309/343-8131. (4)

**GIBSON CITY:** Family Practitioner—Excellent opportunity in East Central Illinois; modern, well equipped hospital with attached private SNF; new professional office space and incentives available; rural community within 30 minutes of major university, tertiary care center, metropolitan area with major shopping, recreational and cultural activities. Contact: Daniel J. Marion, Executive Vice President, Gibson Community Hospital, Gibson City 60936 (217-784-4251). (9)

**KEWANEE:** 108 bed community hospital involved in an expansion program is interested in recruiting family practitioners to our service area of 35,000 population. Several practice opportunities exist in group or solo practices. The population centers in the service area range from 15,000 in population and less. Contact Harold L. Bischoff, Kewanee Public Hospital, 719 Elliott Street, Kewanee 61443 (309) 853-3361. (4)

**LINCOLN:** 20 miles from Southern Illinois University School of Medicine in Springfield and halfway between St. Louis and Chicago on I55. Need two family practice physicians for growing practice. Office facilities available with 10 man medical group. Contact Mary Richter, 311 Eighth, Lincoln 62656. (217/732-9681). (4)

**MARSHALL:** Population 4,000. County seat of Clark County. Rural community. Comparatively new medical center with available space for 4 doctors. Presently have 2 doctors. Facility fully equipped with lab, x-ray, therapy, emergency room, pharmacy. Located 17 miles from three major hospitals. Have excellent school system and recreational facilities. CONTACT: Donald B. Smitley, Admin., 410 N. 2nd St., P.O. Box 219, Marshall 62441, 217-826-2358. (4)

**METROPOLIS:** 8,000 population. Openings in Family Practice. 4 physicians at present. Southern Il. on Ohio river. Complete office facilities annexed to hospital. Financial assistance. Near two large lakes and recreational area. Just completing construction and renovation. 6-bed IC-CCU and 51 MS beds. CONTACT: Loren L. Erwin, POB 111, Metropolis 62960 (618-524-2176). (9)

**SULLIVAN:** Population 5,000. New medical center with complete office and ancillary services available. Near universities and colleges. All recreational facilities nearby. CONTACT: Sandra Elder, 2 W. Adams, Sullivan 61951 (217) 728-8316 or (217) 728-4186. (4)

TENTH ANNUAL CONGRESS/CME

## **Determining What Physicians Need to Learn—Needs Identification In Continuing Medical Education**

*September 24-25, 1982, at the Drake Oakbrook Hotel, West  
22nd St. at York Road, Oak Brook, Illinois.*

This year's Congress is the third in a four-year cycle covering the fundamentals of CME planning. The major emphasis in 1982 is on *how to identify physicians' learning needs*; the program will also include a variety of other topics that can satisfy CME concerns of physicians in Illinois and throughout the nation.

In response to demand, this year's special anniversary Congress has been extended to two full days—Friday afternoon and evening, all day Saturday—to offer you a wider choice of small group workshops and free time for informal discussion.

Highlighting this year's program will be Edmund D. Pellegrino, M.D., John Carroll University Professor of Medicine and Medical Humanities, Georgetown University Medical Center, Washington, D.C.

Among the small group workshops this year will be: Differentiating between Needs and Interests, Simulations in Needs Identification, Malpractice Data in Needs Identification, Expert Observation as Needs Identification, Interest Surveys and Audience Feedback, and Patient-Problem Inventory & Self Assessment Exams in Needs Identification.

Other workshops will include Introduction of Microcomputers, Introduction to Evaluation, and two special workshops for non-physician medical educators and administrative support staff.

For additional information, write or call the Illinois Council/CME, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603, (312) 236-6110.



# Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510, Chicago, IL 60603, (312) 236-6110.

*Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.*

## SEPTEMBER

### Cardiovascular

#### Cardiology Update—Calcium Channel Blockers

**For:** MD's. Symposium, Sept. 21, 7:00 p.m., Vandalia. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 3 hours; AAFP Prescribed, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Clinical Hypnosis

#### Workshops on Clinical Hypnosis

**For:** MD's, therapists. Workshop, Sept. 23-25, Milwaukee, WI. **Sponsor:** American Society of Clinical Hypnosis, Education and Research Foundation, 2250 E. Devon Ave., #336, Des Plaines 60018. **Fee:** \$125-375. **Reg. limit:** 150. **Credit:** Category 1, 22 hours; AAFP Elective, 22 hours; APA, 22 hours; AGD, 22 hours. **Contact:** Wilma Kafitz. **Phone:** 312/297-3317.

### Dermatology

#### Specialty Review in Dermatology

**For:** Dermatologists. Lecture, Sept. 13 (5 days), Rosemont. **Speaker:** Marshall Blankenship, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Reg. limit:** 150. **Credit:** Category 1, 37 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Endocrinology

#### Integrated Approach to Diseases of the Endocrine System

**For:** MD's. Symposium, Sept. 17, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Internal Medicine

#### New Developments in Diabetes

**For:** MD's. Symposium, Sept. 23, 1:00 p.m., Red Bud. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Internal Medicine

#### Specialty Review in Nephrology

**For:** Nephrologists, Internists. Lecture, Sept. 20 (5 days), Chicago. **Speaker:** Norman Simon, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 150. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Internal Medicine

#### Specialty Review in Rheumatology

**For:** Rheumatologists, Internists. Lecture, Sept. 20 (5 days), Chicago. **Speaker:** William Arnold, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Medicine

#### Thrombocytosis

**For:** MD's. Lecture, Sept. 1, 11:00 a.m., North Chicago. **Sponsor:** UHS/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

#### Unstable Angina

**For:** MD's. Lecture, Sept. 8, 11:00 a.m., North Chicago. **Sponsor:** UHS/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

#### Malignant Mesothelioma

**For:** MD's. Lecture, Sept. 15, 11:00 a.m., North Chicago. **Sponsor:** UHS/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

#### Fabry's Disease and Associated Disorders

**For:** MD's. Lecture, Sept. 22, 11:00 a.m., North Chicago. **Sponsor:** UHS/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

#### Pancreatitis

**For:** MD's. Lecture, Sept. 29, 11:00 a.m., North Chicago. **Sponsor:** UHS/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

#### Viral Hepatitis

**For:** Internists, Gastroenterologists, Pediatricians. Symposium, Sept. 24, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, CME, 600 S. Paulina, Rm. 599 AF, Chicago 60612. **Fee:** \$50. **Reg. limit:** 200. **Credit:** Category 1, 7 hours. **Contact:** Edi Inglesias. **Phone:** 312/942-7095.

### Medicine

### Medicine

### Medicine

### Medicine

### Medicine

### Ophthalmology

#### Retinal Diseases and the Uses of Laser

**For:** Ophthalmologists. Symposium/Workshop, Sept. 9-10, Chicago. **Speaker:** Donald Gass, MD. **Sponsor:** Dept. of Ophthalmology, U of I College of Medicine, 912 S. Wood St., Chicago 60612. **Reg. deadline:** 8/26. **Fee:** \$300, symposium and workshop; \$200, symposium only. **Credit:** Category 1. **Contact:** Sue Korienek. **Phone:** 312/996-8025.

### Pathology

#### Specialty Review in Pathology/Clinical

**For:** Pathologists. Lecture, Sept. 28 (5 days), Chicago. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 150. **Credit:** Category 1, 41 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Psychiatry

#### Psychosomatic Syndrome

**For:** MD's. Symposium, Sept. 15, 1:00 p.m., Marion. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Radiology

#### New Advances in Diagnostic Radiology

**For:** MD's. Symposium, Sept. 30, 1:00 p.m., Litchfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Trauma

#### Inter Hospital Trauma Conference

**For:** MD's. Workshop, first Friday of each month, Chicago Athletic Assn., Chicago. **Sponsor:** Loyola University Medical Center, 2160 First Ave., Rm. 3305, Maywood 60153. **Reg. deadline:** none. **Fee:** none. **Reg. limit:** none. **Contact:** W. Peter Geis, M.D.

## Tenth Illinois Congress on Continuing Medical Education

### "Determining What Physicians Need to Learn— Needs Identification in CME"

September 24-25, 1982  
Drake Oakbrook Hotel

This year's special anniversary program has been expanded to two full days and will include a variety of workshops on how to identify learning needs in your physician audience and how to select appropriate needs identification procedures.

Special keynote speaker will be Edmund D. Pellegrino, M.D., John Carroll University Professor of Medicine and Medical Humanities, Georgetown University Medical Center, Washington, D.C.

Full program details will be available after June 15; to receive a brochure and enrollment form, write or call . . .

Illinois Council on Continuing Medical Education  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110

# OCTOBER

## Geriatrics

### Mainstreaming the Aged Disabled

**For:** MD's. Course, Oct. 19-20, Chicago. **Speakers:** Henry Betts, MD; Thomas Byerts. **Sponsor:** Rehabilitation Institute of Chicago/Education and Training Center, 345 E. Superior St., Chicago. **Fee:** \$100. **Credit:** Category 1, 14 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

## Geriatrics

### Aging and Illness in Primary Care

**For:** MD's. Symposium, Oct. 14-15, Madison, WI. **Sponsor:** U of WI—Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 14 hours; AOA, 14 hours; AAFP Prescribed, applied for. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Medical/Legal

### Medical/Legal Aspects of Claims for Neck/Shoulder Pain

**For:** MD's. Lecture, Oct. 6, Chicago. **Sponsor:** UHS/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 7½ hrs. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Medicine

### Critical Care Symposium

**For:** MD's. Lecture, Oct. 7-10, Marriott's Lincolnshire Resort, Lincolnshire. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Reg. deadline:** 10/7. **Fee:** \$295. **Credit:** Category 1, 21 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Microbiology/Immunology

### Laboratory Diagnosis

**For:** MD's. Symposium, Oct. 7, 1:00 p.m., Lincoln. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Neurology

### Contemporary Topics in Neurology

**For:** Neurologists, Psychiatrists. Lecture, Oct. 25 (5 days), Chicago. **Speakers:** Frank Rubino, MD; Susan Olson, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$375. **Reg. limit:** 150. **Credit:** Category 1, 42 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## OB/GYNE

### Specialty Review in OB/GYNE: Practical Aspects

**For:** Obstetricians, Gynecologists. Lecture, Oct. 11 (5½ days), Chicago. **Speaker:** M. LeRoy Sprang, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$425. **Reg. limit:** 300. **Credit:** Category 1, 45 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Pathology

### Specialty Review in Pathology/Anatomic

**For:** Pathologists. Lecture, Oct. 4 (6 days), Chicago. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$425. **Reg. limit:** 200. **Credit:** Category 1, 48 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Rheumatology

### Clinical Rheumatology

**For:** MD's. Symposium, Oct. 21, 1:00 p.m., Pittsfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Stroke

### Stroke and Neurosurgical Rehabilitation

**For:** MD's. Course, Oct. 12-13, Chicago. **Speaker:** Paul Kaplan, MD. **Sponsor:** The Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago 60611. **Fee:** \$250, MD; \$175, resident. **Credit:** Category 1, 14 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

## Surgery

### Specialty Review in General Surgery, Part I

**For:** General Surgeons. Lecture, Oct. 11 (11 days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$600. **Reg. limit:** 400. **Credit:** Category 1, 98 hours. **Contact:** Robert Baker. **Phone:** 312/733-2800.

## Surgery

### Fiberoptic Esophagogastroduodenoscopy

**For:** Surgeons, Internists, Gastroenterologists. Lecture, Oct. 4 (2½ days), Chicago. **Speaker:** C. Thomas Bombeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Urology

### Kidney-Testis Cancer

**For:** Urologists. Course, Oct. 7-9, Airport Sheraton, Indianapolis, IN. **Sponsor:** American Urological Assn., P. O. Box 25147, Houston, TX 77265. **Reg. deadline:** 10/7. **Fee:** \$230, members; \$260, non-members. **Reg. limit:** 150. **Credit:** Category 1, 16 hours. **Contact:** Alice Henderson. **Phone:** 713/790-6070.

# NOVEMBER

## Cardiology

### Cardiac Rehabilitation

**For:** GP's, FP's, Internists. Seminar, Nov. 5-6, Hyatt Lincolnwood, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Drive E., Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **Contact:** Doris Price. **Phone:** 800/525-8651 x 123.

## Emergency Care

### Emergency Department Management

**For:** MD's. Symposium, Nov. 18-19, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Malignant Disease

### Oncology Symposium

**For:** MD's. Symposium, Nov. 17, 1:00 p.m., Marion. **Sponsor:** SIU School of Medicine, P. O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## OB/GYN

### OB/GYN Seminar-at-Sea

**For:** MD's. Symposium/Cruise, Nov. 27-Dec. 7, Caribbean. **Sponsor:** SIU School of Medicine, P. O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 48 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Pharmacology

### Practical Pharmacology

**For:** MD's. Symposium, Nov. 9, 7:00 p.m., Effingham. **Sponsor:** SIU School of Medicine, P. O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 3 hours; AAFP Prescribed, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Respiratory Critical Care

### Respiratory Critical Care Symposium

**For:** MD's. Symposium/workshops, Nov. 4-6, Madison, WI. **Sponsor:** U of WI—Extension, CME, 465B WARF Bldg., 610 Walnut, Madison, WI 53706. **Fee:** \$225. **Reg. limit:** none. **Credit:** Category 1, 18 hours; AOA, 18 hours; AAFP Prescribed, applied for. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Sports Medicine

### Athletic Injuries

**For:** MD's. Symposium, Nov. 3, 1:00 p.m., Alton. **Sponsor:** SIU School of Medicine, P. O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Surgery

### Burns

**For:** MD's. Symposium, Nov. 11, 1:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Terminal Illness

### Hospice

**For:** MD's. Lecture, Nov. 5, 8:00 a.m., Chicago. **Speaker:** Sheldon Burchman, MD. **Sponsor:** Grant Hospital, CME, 550 W. Webster Ave., Chicago 60614. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Sharon Smith. **Phone:** 312/883-2112.

## CME ACCREDITATIONS

The ISMS Committee on CME Accreditation has approved the CME programs of the following institutions:

Gottlieb Memorial Hospital, Melrose Park  
Illinois Society of Allergy  
& Clinical Immunology  
Northwest Community Hospital,  
Arlington Heights  
Oak Forest Hospital  
Oak Park Hospital  
Provident Hospital, Chicago  
St. Anne's Hospital, Chicago  
St. Francis Hospital-Medical Center, Peoria  
Shriners Hospital  
for Crippled Children, Chicago  
Suburban Medical Center,  
Hoffman Estates

## Independent Study

The University of Wisconsin offers a number of courses for primary care physicians that enable you to continue learning in the privacy of your home or office, studying at your convenience. Available are:

Pharmacology  
Infectious Diseases  
Pediatrics  
Family Medicine  
Hematology

Each course carries Category 1 credit, ranging from 30 to 45 hours. Each is updated regularly.

For complete details, write or call:

Richard H. Hansen  
University of Wisconsin  
Home Study/CME  
WARF Bldg.  
610 Walnut St.  
Madison, WI 53706  
(608) 263-2853



# Classified Advertising

All proposed advertisements should be received by the tenth of the month preceding publication. A surcharge of \$2 will be assessed when a box number is requested.

## CLASSIFIED ADVERTISING RATES

	30 words or less	30 to 50 words	50 to 80 words	80 to 100 words
1 insertion	\$6.00	\$9.00	\$14.00	\$20.00
3 insertions	13.00	15.00	28.50	41.50
6 insertions	20.00	26.50	46.00	66.00
12 insertions	33.00	44.00	77.00	110.00

## POSITIONS AND PRACTICE

**MIXED MULTI-SPECIALTY INCORPORATED GROUP**—30 miles south of Chicago seeks Family Practitioner. Life, disability, malpractice insurance and all medical dues paid. X-ray and lab in building. Excellent hospital facilities half block from office. Salary, profit sharing and pension plan \$54,000. Partnership after one year. Write or call collect, Mr. E. Karmis, 1400 Otto Blvd., Chicago Heights, Illinois 60411. Phone (312) 756-4400.

**SMALL TOWN MEDICINE/BIG CITY ADVANTAGES**—Seeking physician to join board certified active family practice group. Thriving community of 10,000, west of Chicago. Modern, well equipped, 3 physician office with full lab and X-ray facilities. 110 bed, primary care hospital 1 mile from office. Salary guarantee, malpractice coverage, other benefits. Opportunity for full partnership. Send resume and C.V. to: P.O. Box 72, Geneva, IL 60134, or call 312-232-2133.

**DOCTORS NEEDED** in Wisconsin and Minnesota, all specialties, all locations. For confidential information, mail your C.V. to Medicus, W62 N281 Washington Avenue, Cedarburg, Wisconsin 53012.

**WANTED PHYSICIAN** to share office or take over lease in Southwest Rockford seeing 20-30 patients daily. Call 815-964-0500 or 312-275-4494.

**IOWA & ILLINOIS:** Young group of Emergency Physicians serving small to medium hospitals and clinics in Iowa and Illinois seek additional physicians to complement present group. Full or part-time Emergency Medicine opportunities or combination FP/ED also available. Excellent compensation package starting at \$71,500 per year for ten 24 hour shifts per month including profit sharing, malpractice, life and disability, medical and dental, and liberal paid vacation and meeting time. Excellent specialty back-up. Send C.V. or call William Foley or Martin Sands, M.D., Box 1469, Bloomington, Illinois 61701; Phone: (309) 452-9321.

**U.S. AIR FORCE MEDICAL CORPS** is currently accepting applications for physicians in the following specialties: Surgery (All subspecialties), Obstetrics/Gynecology, Otorhinolaryngology, Anesthesiology, Urology, Rheumatology, Neurology, Psychiatry. For further information contact: Capt. Brian Legg (312) 263-1207. Call collect or send CV to 111 N. Wabash, Suite 1805, Chicago, Illinois 60602.

**INTERNAL MEDICINE**—Tired of the city rat race? Come to a small town and practice with me! I have an adequate practice waiting for you. Delightful south-western Wisconsin town. Good fishing, hunting, people. Guaranteed salary. Hospital nearby. Time to live and get reacquainted with your family. Ideal opportunity for someone who wants to slow down, but not quit. Write to: J. R. Heersma, M.D., 124 Iowa Street, Muscoda, WI 53573. Call collect evenings: 1-608-537-2774.

**INTERNIST/CARDIOLOGIST**—Multispecialty clinic in community of 20,000 just outside Peoria. 13 physicians with service population of 55,000 looking to add 2 physicians. 225 bed accredited hospital within 2 blocks. Modern facilities and equipment. Negotiable first year salary & complete benefits. Second year salary or % of billings. Excellent school system, parks, rivers, country clubs, conservation area nearby. Please call Phil Kelbe at 414/785-6500 (collect).

**ASSOCIATE DESIRED**—For July 1983-1984, family practitioner to join two family physicians, internist and surgeon in a newly formed group; situated 70 miles west of Chicago in a semi-rural area; family practice oriented hospital with full privileges; equal partnership after 24 months; salary and fringe benefits open to negotiation. Send full vitae to: Irving Frank, M.D., (Director) 954 W. State Street, Sycamore, IL 60178.

**FAMILY PRACTITIONER, PEDIATRICIAN, OB/GYN**, needed by well established small clinic in small town in northern Illinois. Beautiful country. A good place to raise a family. Office with laboratory and x-ray. 150 bed hospital. Please send resume to Box number 1046, Illinois Medical Journal, 55 East Monroe, Suite 3510, Chicago, Illinois 60603.

**GENERAL SURGEON**. Enjoy the security of group practice with the freedom of independent practice. If you are a board certified or board eligible general surgeon, we have an interesting opportunity for you. A general surgeon is needed immediately to form an independent practice in a very desirable Northern Wisconsin community with a drawing population of 100,000. All major specialists available for consultation. A growing community hospital with 240 beds with excellent medical and surgical subspecialty representation. Opportunities for endoscopy and peripheral vascular surgery also exist. For further information write: Administrator, P.O. Box 1646, Wausau, Wisconsin 54401.

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**OFFICE SPACE TO SHARE** Family practitioner seeks physician to share 1200 square ft, fully furnished office in Willowbrook. Close to Hinsdale, Good Samaritan, LaGrange and Suburban Hospitals. Please call 986-1177.

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**3333 WEST PETERSON AVENUE**. Medical suite in medical-dental building. Large common waiting room. Receptionist and switchboard available. Ample parking. Accessible by public transportation. Ideal for any specialty. Call 478-8785.

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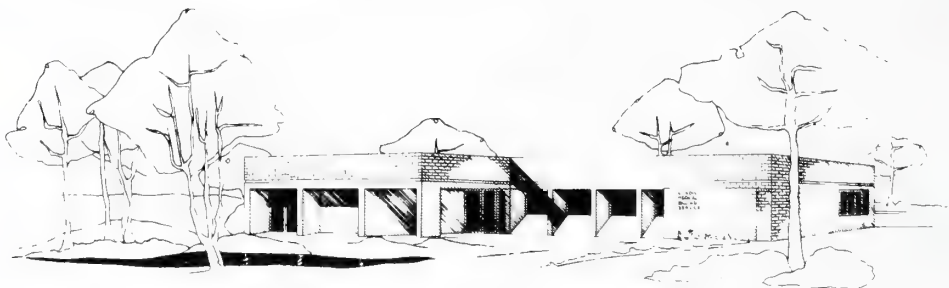


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**Blue Cross®  
Blue Shield®**



# REPORT

## FOR *Illinois Physicians*

### Reciprocity Program Eases Claims Processing

Reciprocity is a program to ease claims handling for physicians' services to Blue Shield patients who become ill or are injured away from home. The system guarantees payment by the local Blue Shield Plan to physicians on a Usual and Customary fee basis. It helps eliminate complications and confusion about membership eligibility and speeds reimbursement.

#### **Basis of Payment**

Payment under the Reciprocity Program is made on the 100% Usual and Customary basis. A physician receives 100% of his usual fee when his fee is "within the range of usual fees charged by physicians of similar training and experience" for services covered under the Reciprocity contract. Because the claims will be processed by Illinois Blue Shield without delay for membership verification, the physician receives payment promptly.

#### **Membership Identification**

Members enrolled in the program will be easily identified by the special identification card which has a double-pointed red arrow and a series of three numbers preceded by the letter "N" within the arrow. The number indicates the "Home Plan" of the member.

When a physician treats a patient having this special card, he files for benefits in the same way he would for an Illinois member with one exception: Both the letter "N" and the code numbers in the arrow, and the subscribers identification number must be entered in the group and subscriber number boxes on the Physician's Service Report form. This enables our claims examiners to identify the claim as a Reciprocity System claim and allows us to coordinate the information with the Home Plan after payment is made. (Example shown on following page.)

#### **Advantages to Illinois Physicians**

The Program has a number of advantages to Illinois physicians:

(1) Payment is guaranteed. As long as the necessary

information is recorded properly on the Physician's Service Report, the claim can be processed and payment made to the physician.

(2) No contact is necessary with another Blue Shield Plan, nor is it necessary to complete a service report form unfamiliar to the physician or his medical assistant. Claims are submitted to Illinois Blue Shield using our own Service Reports.

(3) The physician need not wait for payment while another Plan contacts Illinois Blue Shield about medical charges in our area. We can make payment promptly using the physician's fee data of record.

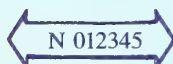
#### **Covered Services**

Benefits under the Reciprocity System include:

- *Surgery*—Wherever performed, including operative or cutting procedures, treatment of fractures or dislocations and endoscopic procedures.
- *Assistant Surgeon*—Coverage when such service is certified as necessary and house staff, interns or residents are not available for such service.
- *Anesthesia*—Wherever performed for covered services when administered by a physician other than the operating physician or his assistant.
- *Radiation Therapy*—Wherever performed for services provided by a physician for X-ray, radium or radioactive isotopes, including rental of materials unless supplied by a hospital or other institution.
- *Diagnostic X-ray*—Including interpretation and report, while the member is a registered bed patient in a hospital when such examination is consistent with the diagnosis, or in the outpatient department of a hospital or in a physician's office when the examination is performed as a direct result of an injury.
- *Laboratory and Pathology*—Examination in a hospital when consistent with the diagnosis or in the outpatient department of a hospital or in a physician's office when the examination is performed as direct result of an injury.
- *In-Hospital Medical Care*—Any medical treatment by an attending physician for a condition not related to surgical or maternity care for the first 30\* days for each

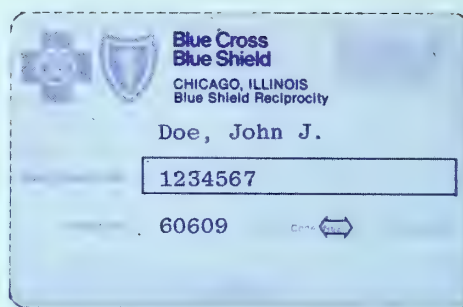


## RECIPROCITY PROGRAM (continued)



A Reciprocity-eligible patient can easily be recognized by a special identification card having a double-pointed arrow with the letter "N" and a three digit "Home Plan" number.

After providing services to a patient, complete a Blue Shield Physician's Service Report form and enter both the letter "N" and three digit number from within the arrow, plus the patient's group and certificate number in the Group No. and Subscriber No. box on the service form as shown.



**Blue Cross  
Blue Shield**



### PHYSICIAN'S SERVICE REPORT

233 North Michigan Avenue  
Chicago, Illinois 60601  
312/661-4200



60609 - 1234567				12345	
Last Name	First Name	Sex	Patient's Age		
Doe	John J.	M	50	1/2/3	
				Married <input checked="" type="checkbox"/>	Single <input type="checkbox"/>
Member's Address		Street	City	State	Zip
Doe John J.		1234 123St.	Chicago, IL		60600

hospital admission. Concurrent medical care benefits will be provided for surgical care patients if the service is rendered by another physician for medical complications.

- *Pulmonary Tuberculosis, Mental Disorders, Drug Addiction and Chronic Alcoholism*—Coverage for the first 30\* days of each hospital admission.

- *Outpatient Emergency Care*—Necessary services performed by a physician wherever performed for an accidental injury or for the first visit at the onset of a medical emergency.

- *Consultations*—Services of another physician when requested by the attending physician for advice in diagnosis or treatment of a condition which requires such special skill or knowledge while the member is a bed patient in a hospital.

The Reciprocity System does not cover maternity services, dental or nursing services, appliances or supplies, operations for cosmetic purposes, care obtained in U.S. Government hospitals, care obtained without cost, Workmen's Compensation cases, services primarily for diagnostic purposes, or claims for Medicare beneficiaries.

If you have any questions regarding the Reciprocity Program, contact your Professional Relations Representative or the Professional Relations Department, Blue Cross and Blue Shield Plan of Illinois, 233 North Michigan Ave., Chicago, Illinois 60601—(312) 938-7059.

*\*Number of days varies according to individual group contract.*

*(This report is a service to the physicians of Illinois)*

# Medicaid-Medicare-Champus Report

## IDPA to Conduct MMIS Seminars in Northern Illinois

**MMIS Seminar Update:** At the urging of ISMS, the Illinois Department of Public Aid is continuing to conduct a second round of educational seminars on how physicians are to submit claims under MMIS. The Department recently concluded its seminars for the Central and Southern Illinois regions. The Northern Illinois programs are scheduled for mid-August. Physicians began to receive notification of the Department's seminar schedule last month.

**MMIS Claim Form:** ISMS staff has received several inquiries regarding the revised MMIS claim form (HCFA 2360). The new supply of forms for physician claims are colored in green rather than red. ISMS was originally informed that red was the only color that the IDPA Optical Character Recognition equipment could interpret and process on MMIS claim forms. However, recent changes in OCR processing technology will allow IDPA to process claim forms in a variety of colors. This color change will serve to identify different provider types by the color of the claim form that is received by IDPA.

Additionally, the revised claim form contains modifications to enhance claims processing and eliminates two major reasons which caused physician claims to reject or suspend. The description of Box 33 on the green colored MMIS claim form has been changed to read "Your Payee Number." The original MMIS claim form identified this section as "Your Employer I.D. Number." During the initial implementation stages of MMIS many physicians experienced claim rejections for completing Box 33 with erroneous information. ISMS requested that IDPA correct the term "Employer I.D. Number" on the revised MMIS claim form in an effort to clarify for physicians the information to be reported in Box 33.

This section, "Box 33 - Your Payee Number" should be completed by using one of the four payee options selected by the physician when he/she reenrolled in the Medical Assistance Program. The character to be entered in this box is a single digit—numbers 1, 2, 3 or 4 as recorded in the payee section of the physician's Provider Information Sheet.

The second change on the revised MMIS form is Box 31. Several physicians experienced claims rejection and/or claims suspension because IDPA's Optical Character Recognition equipment did not correctly identify the physician's address on all claims. The revised form now provides shaded areas below the physician's name to indicate where the complete address of the physician is to be entered on all MMIS claims submitted to IDPA. The remainder of the MMIS form is unchanged.

The Department will continue to accept the original red colored MMIS claim forms until the existing supplies are depleted.

**Reject Codes:** ISMS staff has received inquiries from physicians who are receiving Remittance Advice Sheets for MMIS claim rejections coded with error message R-23. This rejection code was recently developed by IDPA personnel to identify MANG (Medical Assistance-No Grant) recipients who have not met the MANG Spend-Down requirements. These patients will be eligible to receive Medical Assistance Coverage Benefits once the MANG Spend-Down requirements are met. The Department of Public Aid does not assume liability for reimbursing for services provided to recipients affected by MANG Spend-Down until recipients have satisfied IDPA's Spend-Down requirements. Physicians may bill patients directly for medical services rendered during the period that Spend-Down expenses are incurred.

**Medical Assistance Handbooks:** IDPA recently revised Chapter 100 and the General Appendix of the *Medical Assistance Program Handbook for Physicians*. The Department is mailing these revisions to all physicians who are currently enrolled as providers in the Medical Assistance Program. Physicians who have *not* received a copy of the *Medical Assistance Handbook for Physicians* or these revisions should write to the IDPA Provider Participation Unit, P.O. Box 4034, Springfield, IL or call the IDPA Provider Participation Unit using the toll free telephone number (800) 252-8937.



**Consultations:** ISMS has been conducting a series of negotiations with IDPA regarding IDPA definitions of consultation and concurrent care.

The Department of Public Aid considers, for payment purposes, that a consultation is the entire package of physician services required to arrive at a recommendation regarding a patient's condition and/or plan of treatment.

The revised sections of IDPA's *Handbook* will become effective for services rendered on or after *September 1, 1982*. Please watch your mail for IDPA's notification of these revised consultation and concurrent care sections of the *Handbook*. Numerous changes have taken place with consultations and concurrent care definitions and this revised material should be reviewed carefully.

A major change that was negotiated between ISMS and IDPA is that IDPA will reimburse a physician for the initial consultation as a consultation regardless of any follow-up visits by the consulting physician. Currently, if a consultant continues to provide follow-up care to the patient, IDPA assumes that the consultant has replaced the attending physician as the *new* attending physician. This assumption caused IDPA not to reimburse the initial consultation as a consultation, but as an initial office/hospital visit and the follow-up care by the consultant as subsequent office/hospital visits.

**6-Month Timely-Submittal Rule:** Physicians are reminded that IDPA reinstituted its 6-month timely-submittal rule as of June 30, 1982. MMIS claims that are submitted to IDPA on and after this date are subject to the 6-month timely-submittal rule. Office managers are also reminded to develop a "tickler" file in order to ensure that physician claims for service are submitted and received at IDPA within the 6-month time frame.

**Medicare Assignments:** ISMS staff has received some inquiries from physicians regarding Medicare reimbursements forwarded to beneficiaries when the physician has accepted assignment on the Medicare claim. Physicians who wish to accept the assignment on Medicare Part B claims should complete the appropriate box in Section 12 of SSA 1490 claim form indicating that the physician accepts assignment. *Those claims submitted to EDS-F, the Medicare Part B carrier, that do not have Box 12 completed are processed as unassigned claims.* Medicare's Explanation of Medical Benefits and reimbursements will be forwarded to the beneficiary on all unassigned Medicare claims. EDS-F will forward reimbursements to the physician only if Box 12 indicates that the assignment will be accepted.

Additionally, several physicians have experienced difficulties in obtaining the appropriate Medicare Explanation of Medical Benefits (EOMB) to submit to IDPA on Medicare-/Medicaid eligible patients. EDS-F has developed a special EOMB for use by IDPA on patients with Medicare/Medicaid coverage. EDS-F will automatically generate this EOMB if the physician reports that the patient is eligible for Medicaid coverage by stating "*Illinois Department of Public Aid*" in Box 5 of the Medicare claim form SSA 1490. If physicians experience difficulties in obtaining the proper EOMB to submit to IDPA on crossover claims, they may contact the EDS-F professional relations staff at (312) 635-6020.

Finally, physicians who have questions or require further clarification of Medicare, Medicaid or CHAMPUS policies and procedures should not hesitate to call their ISMS Field Representative at (312) 782-1654.

Physicians in Cook County should direct routine inquiries to Christine Szuflita at the Chicago Medical Society offices (312) 670-2550.

# President's Page

## WOMEN PHYSICIANS AND ORGANIZED MEDICINE



A woman has yet to be elected to the office of president of the United States, but it is undoubtedly only a matter of time before this will occur. In the decades since World War II, women have played an increasingly important role in the political activities of many countries and in several of them they have held the highest elective office. This is equally true in business and professional fields.

In the profession of medicine, women have an even longer history of distinguished accomplishment. Today, many of the leaders in both academic and clinical medicine are women. They are to be found in the highest positions of every specialty. This is not surprising when one considers that of the 482,935\* practicing physicians in the United States 58,540\* are women and that at the present time women comprise 26.5%\* of medical students in United States schools.

There is one area of medical endeavor, however, in which women have yet to achieve their potential and that is in organized medicine. There have been some notable exceptions and we in the Illinois State Medical Society are fortunate to have had some of these distinguished women as colleagues. But, generally speaking, women physicians have yet to exert the influence in medical politics warranted by their growing numbers. This is a great pity because the problems facing physicians in today's health care delivery system are the same for women and men. The participation of women in dealing with these problems would make the efforts of the medical profession, as a whole, much more effective.

ISMS appreciates that it is important for all women physicians to subscribe their talents and energies to help resolve the problems facing the medical profession and the public we serve in Illinois. In pursuit of this, the membership committee is directing a specific appeal to women physicians to become members of ISMS and to participate actively in accomplishing the mission of all physicians to serve the health care needs of our patients in the best way we can, both medically and economically.

A handwritten signature in dark ink, reading "C. C. Wiggishoff M.D." in a cursive style.

Cyril C. Wiggishoff, M.D., President

\*Source American Medical Association unofficial 1981 figures.



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most predictable modalities...



*Lepus lagopus*

## THE ARCTIC FOX

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Like clockwork, the fox's gray-brown fur turns completely white as the winter solstice approaches, and then returns to its normal color during the spring thaw. The fox's coat also undergoes a smoky blue phase. This cyclical camouflage enables the fox to blend readily with the changing scenery of its environment, masking it from predators and prey.

The arctic fox: an animal whose coat is always in season. Few animals in nature have such a predictable pattern of adaptability.

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Librium. A natural selection for your clinically anxious patients.



For the treatment of anxiety

5 mg, 10 mg, 25 mg capsules  
**Librium®** <sup>®</sup> <sub>IV</sub>  
 chlordiazepoxide HCl/Roche  
 one of man's



**Librium®** (N)  
(chlordiazepoxide HCl/Roche)  
5 mg, 10 mg, 25 mg capsules

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Known hypersensitivity to drug

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. **Oral—Adults:** Mild and moderate anxiety disorders and symptoms, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* **Geriatric patients:** 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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## Clinics for Crippled Children Listed for October

Thirty-nine clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 26 general clinics, 10 cardiac clinics, one for children with neurological problems, and two for children with myelodysplasia. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- 1 Division Cardiac - U. of I. at the Medical Center
- 4 Peoria Myelodysplasia - St. Francis Med. Ctr.
- 5 Danville - Lakeview Hospital
- 5 Quincy - Blessing Hospital
- 5 Maryville - Oliver C. Anderson Hospital
- 5 Wheaton - Marianjoy Rehabilitation Hospital
- 5 Park Ridge General - PM - Lutheran General Hospital
- 5 Park Ridge Cardiac - AM - Lutheran General Hospital
- 7 Anna - Anna Mental Health and Developmental Center
- 7 Sterling - Community General Hospital
- 7 Hinsdale - Hinsdale Sanitarium
- 7 Lake County Cardiac - Victory Mem. Hosp.
- 12 East St. Louis - Community Hospital
- 13 Champaign-Urbana - McKinley Health Service Center
- 13 Chicago Heights General - St. James Hosp.
- 13 Joliet - St. Joseph's Hospital
- 13 Aurora General - Mercy Center for Health Care Services
- 14 Rockford - St. Anthony Hospital
- 14 Mt. Vernon - Good Samaritan Hospital
- 14 Litchfield - St. Francis Hospital
- 14 Aurora Cardiac - Mercy Center for Health Care Services
- 14 Kankakee General - St. Mary's Hospital
- 15 Kankakee Cardiac - St. Mary's Hospital
- 18 Belleville - Belleville Memorial Hospital
- 18 Peoria Cardiac - St. Francis Medical Center
- 18 Chicago Heights Cardiac - St. James Hosp.
- 18 Maywood (Ortho/Ped) - Loyola Medical Ctr.
- 19 Rock Island General - Moline Public Hospital
- 19 Decatur - Decatur Memorial Hospital
- 20 Springfield Ped-Neuro - Memorial Med. Bldg.
- 20 Elgin MM - Sherman Hospital
- 20 Chicago Heights General - St. James Hosp.
- 21 Bloomington (no Peds) - Mennonite Hospital
- 21 Elmhurst Cardiac - Memorial Hospital of DuPage County
- 25 Peoria Cardiac - St. Francis Medical Ctr.
- 25 Maywood (Ortho/Ped) - Loyola Medical Ctr.
- 25 Chicago Heights Cardiac - St. James Hosp.
- 26 Peoria General - St. Francis Med. Center
- 28 Champaign Children's Home - Champaign

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



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# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This month's Viewbox was prepared by Kenneth Baliga, M.D. and Terrence C. Demos, M.D., Loyola University Medical Center, Maywood.*

*This 30-year old man has had diarrhea for six months and has lost 20 pounds. During this time, he was hospitalized and evaluated at two different institutions. Two small bowel biopsies showed no abnormalities. Both legs are edematous. A radionuclide test indicates protein loss in the feces. He is anemic. A previous small bowel series showed diffuse abnormalities. Figures 1 and 2 are from a current small bowel series.*



Figure 1.

Small bowel series at 30 minutes. Dilated bowel with nodules (arrows).



Figure 2.

Small bowel series at 90 minutes. Dilated bowel, fragmentation of barium in proximal jejunum and nodules (arrows).

## Your diagnosis?

- (1) Non-Hodgkin Lymphoma
- (2) Non-tropical sprue
- (3) Crohn disease
- (4) Lymphangiectasia
- (5) Whipple disease

*(Continued on page 200)*

# Special Articles

## Professionalism in Public Affairs

BY JAMES D. NOWLAN Ph.D.,/URBANA

The purpose of this article is to provide an outline of the uses and meanings of the terms "professional" and "professionalism."<sup>1</sup> We will then make suggestions about how allied health professionals may enhance the degree of professionalism accorded them.

The terms dissected in this paper are commonly used to: (1) accord respect and dignity to the type of work being done; (2) denote full-time performance, as in "professional athlete," or "professional lobbyist;" (3) convey the idea of great skill or proficiency, as when we say "he's a real professional," whether the person be a mechanic, piano tuner, or hair stylist and (4) represent aspirations and self-concepts of occupational groups, as suggested by the 20 or more groups that sought, all unsuccessfully, to achieve occupational licensure by the state of Illinois in 1979-80. The recreation therapists, electrologists, prosthetists and others who sought such status did so, at least in part, as a means of bestowing on themselves the mantle of professionalism.

For some groups the appellation is elusive. As a former elected member of the Illinois General Assembly, this writer knows that many of his colleagues devoted full time to government and politics, displayed great skills, conceived of

themselves as professionals and understood that their fellow citizens accorded respect to the work of representative democracy. Nevertheless, few people naturally link the terms professional and professionalism to politics and politicians.

The terms we are analyzing are bestowed. They cannot be self-imposed, at least not credibly.

### Occupation vs. Profession

Eight characteristics differentiate occupations from professions. The degree to which a group possesses each characteristic determines its place along a continuum, moving from that of pure occupation on one end to pure profession on the other. The criteria are enumerated below.

- (1) The extent to which the work of a group is based upon a systematic body of theory and knowledge.
- (2) Closeness to values and needs central to society, *e.g.*, justice and health. Funeral directors emphasize their role of counseling the bereaved rather than their function of preparing the bodies of the deceased; the former is perceived to address a more central, immediate, and personal need than is the latter.
- (3) The length and rigor of the training and education required.
- (4) The extent to which service is superior to self-interest. The key here is probably not really the motivation, but the extent to which the work emphasizes the ideal of service to patients, clients, and the public and the extent to which this claim is publicly acknowledged. Do those involved have their clients' "best interests at heart?" Vocations that are looked to for their service to the public, such as health care and legal services, are more likely to be viewed as professions than those requiring aggressive outreach and salesmanship for their

---

**JAMES D. NOWLAN, Ph.D.**, is a director of the graduate programs in public administration, University of Illinois, Urbana. He has served as full time acting director for the Illinois Department of Registration and Education and is a former member of the Illinois House of Representatives. The recipient of "outstanding legislator" awards from the Independent Voters of Illinois and biennial poll of the *Illinois Political Reporter* magazine, he has owned and operated a group of three community newspapers in Stark and Peoria counties.



success. The latter traits appear to give off signals of self-interest.

- (5) The degree of autonomy and self-control over activities and participants. This characteristic is reflected in states—not including Illinois—where a wide range of occupations have autonomous licensing and regulation boards. Another dimension of this characteristic is the extent to which an occupation is free of supervision by others, thereby suggesting a level of competence and skill that only peers are capable of judging.
- (6) The sense of commitment. Do people go into a field by virtue of a “calling,” with that word’s connotations of the divine, or do people perform the work without any long-term commitment?
- (7) The sense of community. According to Goode, a “professional community” is identified by such things as: (a) members bound by a sense of identity, (b) members who share values in common, (c) agreement on role definitions, (d) a common language, and (e) a community with power over its members.<sup>2</sup>
- (8) The existence of a code of ethics. Professionals have a code that is fully developed, visible, and acknowledged both within as well as outside the occupation. This reflects an attempt to assure that only the highest level of performance is being rendered or will be tolerated.

### Challenges for Professionals

Many vocations are allied by mutual interests. Civil, structural, electrical and mechanical engineers often group themselves together in what is called “professional engineering,” for example. In a similar fashion, numerous separate health vocations are sometimes referred to as the “allied health professions.” Klegon has noted several traits that seem to characterize vocational groupings such as the so-called allied health professionals.<sup>3</sup>

1. There are conflicts among occupations within a grouping.
2. An occupation lacking sufficient resources cannot expect to become dominant.
3. The overall appearance of professionalism generated by one or two occupations within a grouping can benefit all occupations which are able to fit under the umbrella.
4. The explosion of information available and necessary to an occupational grouping leads to the role of “super consultant” for some

within “lead” or primary occupations, while generating a degree of interdependence among occupations within a grouping.

Conflict is one of several traits that can decrease the degree of professionalism accorded by society. Others that have negative consequences include actions perceived to be clearly self-interested, and increases in prices charged by an occupation.

Additionally, public opinion research has shown increasingly negative attitudes in recent years toward “bigness” of any kind, whether Big Government, Big Labor, or Big Business. This generalization may extend in some degree to long-standing and visible vocations, such as medicine and law. A respected pollster told this writer that if you want to sell a new product or idea don’t put a doctor or lawyer on the television screen; instead, put a baseball star or other celebrity forward to do the job.

In 1977 the Gallup Poll asked a standard national sample to rate a list of occupations according to the honesty and ethical standards of people in the respective fields, whether very high, high, average, low or very low. While only clergymen received higher marks than medical doctors, it may be sobering to point out that fully half the sample viewed physicians as either average, low, or very low on this scale.

### Professionalism in Public Affairs

Professionalism is not an absolute. Rather, it is an attribute accorded by degree. Once a certain degree of professionalism is achieved, it must be sustained through continuous positive reinforcement. Of course, there are some forces, such as increased business costs, that are beyond the control of a profession and which tend to erode the degree of professionalism accorded it.

Upcoming sessions of the Illinois General Assembly present an excellent yet challenging setting in which allied health professions in this state can enhance, or diminish, the degree of professional respect they are accorded.

Nobody needs and wants good solid information more than a state lawmaker. The range of complex, often arcane subjects which he or she must address is bewildering, from banking structures to land reclamation to nursing staff shortages. Health care is only one of many major issue categories. Lawmakers turn to groups they respect for assistance. Respect is based upon many of the same criteria that determine the degree of professionalism, *i.e.*, knowledge, service over self-interest, sense of commitment.

Interest groups participate in varying degrees in the process of educating lawmakers. They distil

complex problems into options, shape policies and set agendas. If the cues provided by related groups in health care are not generally consonant, then busy lawmakers may simply put the conflict and the problem aside.

Thus the challenge for allied health groups is to address, if not always resolve, internal conflict in a professional manner. Ideally, there should be informal, expert deliberation among concerned allied groups. These should show a capacity to see beyond their own, understandable objectives to the development of strategies for addressing the problems in behalf of allied constituencies.

### A Moderate Suggestion

Interest groups within subject areas such as the environment and energy are experimenting with the concept of "consensus building."<sup>4</sup> The idea is to develop a forum where groups with common interests but differing perspectives—environmentalists and public utilities, for example—can come together in advance of, or apart from, the legislative process. The neutral forum would attempt to establish common objectives, a common language, areas of potential agreement, and

methods for conflict resolution. The forum would also recognize and try to delimit areas of irconcilable conflict.

Certainly disagreement and conflict are natural. Nevertheless, dissonant cues from related professional groups tend to dismay, even confuse, lay legislators. Efforts to reduce dissonance and to place service ahead of self-interest should enhance the degree of professionalism accorded a group. This should in turn enhance that group's overall effectiveness in public affairs. ◀

### REFERENCES

1. For a broader discussion of this topic, see Greenwood, Ernest: "Attributes of a Profession," *Social Work* 45-55, July, 1957; Krause, Elliott A.: *THE SOCIOLOGY OF OCCUPATIONS*, Little, Brown & Co., Boston, 1971; Pavalko, Ronald M.: *SOCIOLOGY OF OCCUPATIONS AND PROFESSIONS*, Peacock, Itasca, Illinois, 1971.
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3. Klegon, Douglas: "The Sociology of Professions: An Emerging Perspective," *Sociology of Work and Occupations* 5: 259-283, August, 1979.
4. For further information, write the Environmental Consensus Forum, 1201 W. Nevada, Urbana, IL 61801.

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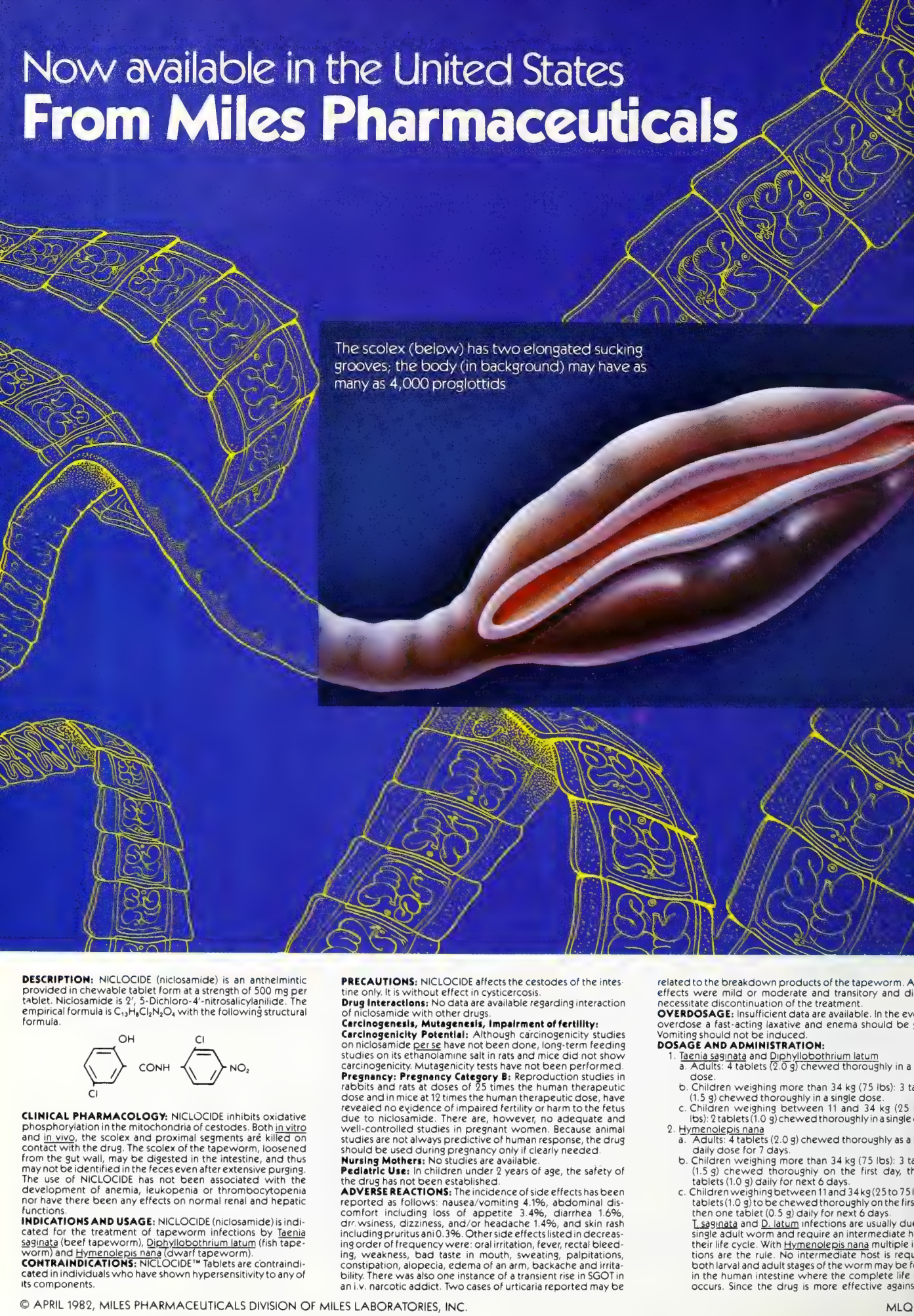
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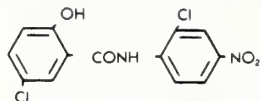


# Now available in the United States From Miles Pharmaceuticals



The scolex (below) has two elongated sucking grooves; the body (in background) may have as many as 4,000 proglottids

**DESCRIPTION:** NICLOXIDE (niclosamide) is an anthelmintic provided in chewable tablet form at a strength of 500 mg per tablet. Niclosamide is 2', 5-Dichloro-4'-nitrosalicylanilide. The empirical formula is  $C_{11}H_6Cl_2N_2O_4$  with the following structural formula.



**CLINICAL PHARMACOLOGY:** NICLOXIDE inhibits oxidative phosphorylation in the mitochondria of cestodes. Both *in vitro* and *in vivo*, the scolex and proximal segments are killed on contact with the drug. The scolex of the tapeworm, loosened from the gut wall, may be digested in the intestine, and thus may not be identified in the feces even after extensive purging. The use of NICLOXIDE has not been associated with the development of anemia, leukopenia or thrombocytopenia nor have there been any effects on normal renal and hepatic functions.

**INDICATIONS AND USAGE:** NICLOXIDE (niclosamide) is indicated for the treatment of tapeworm infections by *Taenia saginata* (beef tapeworm), *Diphyllobothrium latum* (fish tapeworm) and *Hymenolepis nana* (dwarf tapeworm).

**CONTRAINDICATIONS:** NICLOXIDE™ Tablets are contraindicated in individuals who have shown hypersensitivity to any of its components.

**PRECAUTIONS:** NICLOXIDE affects the cestodes of the intestine only. It is without effect in cysticercosis.

**Drug Interactions:** No data are available regarding interaction of niclosamide with other drugs.

**Carcinogenesis, Mutagenesis, Impairment of fertility:**

**Carcinogenicity Potential:** Although carcinogenicity studies on niclosamide *per se* have not been done, long-term feeding studies on its ethanolamine salt in rats and mice did not show carcinogenicity. Mutagenicity tests have not been performed.

**Pregnancy: Pregnancy Category B:** Reproduction studies in rabbits and rats at doses of 25 times the human therapeutic dose and in mice at 12 times the human therapeutic dose, have revealed no evidence of impaired fertility or harm to the fetus due to niclosamide. There are, however, no adequate and well-controlled studies in pregnant women. Because animal studies are not always predictive of human response, the drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** No studies are available.

**Pediatric Use:** In children under 2 years of age, the safety of the drug has not been established.

**ADVERSE REACTIONS:** The incidence of side effects has been reported as follows: nausea/vomiting 4.1%, abdominal discomfort including loss of appetite 3.4%, diarrhea 1.6%, drowsiness, dizziness, and/or headache 1.4%, and skin rash including pruritus and 0.3%. Other side effects listed in decreasing order of frequency were: oral irritation, fever, rectal bleeding, weakness, bad taste in mouth, sweating, palpitations, constipation, alopecia, edema of an arm, backache and irritability. There was also one instance of a transient rise in SGOT in an i.v. narcotic addict. Two cases of urticaria reported may be

related to the breakdown products of the tapeworm. All effects were mild or moderate and transitory and did not necessitate discontinuation of the treatment.

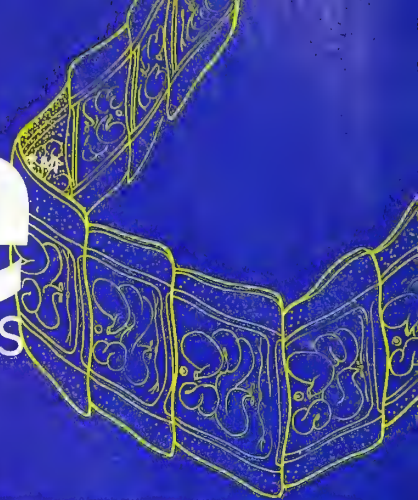
**OVERDOSAGE:** Insufficient data are available. In the event of overdose a fast-acting laxative and enema should be given. Vomiting should not be induced.

## DOSEAGE AND ADMINISTRATION:

1. *Taenia saginata* and *Diphyllobothrium latum*
    - a. Adults: 4 tablets (2.0 g) chewed thoroughly in a single dose.
    - b. Children weighing more than 34 kg (75 lbs): 3 tablets (1.5 g) chewed thoroughly in a single dose.
    - c. Children weighing between 11 and 34 kg (25 lbs): 2 tablets (1.0 g) chewed thoroughly in a single dose.
  2. *Hymenolepis nana*
    - a. Adults: 4 tablets (2.0 g) chewed thoroughly as a daily dose for 7 days.
    - b. Children weighing more than 34 kg (75 lbs): 3 tablets (1.5 g) chewed thoroughly on the first day, then 2 tablets (1.0 g) daily for next 6 days.
    - c. Children weighing between 11 and 34 kg (25 to 75 lbs): 1 tablet (0.5 g) to be chewed thoroughly on the first day, then one tablet (0.5 g) daily for next 6 days.
- T. saginata* and *D. latum* infections are usually due to a single adult worm and require an intermediate host in their life cycle. With *Hymenolepis nana* multiple infections are the rule. No intermediate host is required for both larval and adult stages of the worm may be found in the human intestine where the complete life cycle occurs. Since the drug is more effective against



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NICLOCIDE works promptly and simply. After tablets are chewed thoroughly and washed down with a little water (for children tablets should be pulverized and mixed

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NICLOCIDE Tablets are taken as a single dose after breakfast. Tablets must be chewed or pulverized thoroughly and washed down with a little water. No special diet or preparation is necessary except in patients who are constipated. In these cases, a thorough cleansing of the bowels may be required before treatment. The avoidance of alcohol during treatment is the only other requirement.

\*A drastic saline purge, such as magnesium sulfate or sodium sulfate should be given two hours after the NICLOCIDE dose if it is required that the tapeworms be expelled rapidly and in one piece.

†In infections with beef tapeworm (*T. saginata*) and fish tapeworm (*D. latum*) one single dose is sufficient; for infections with dwarf tapeworms (*H. nana*) a seven-day treatment is recommended (SEE FULL PRESCRIBING INFORMATION ON THESE PAGES).

mature than the larval stage, therapy must be extended over several days to cover all stages of maturation. Patients with *H. nana* must be instructed to observe strict personal and environmental hygiene to avoid autoinfection with this parasite.

3. NICLOCIDE™ must be thoroughly chewed and then swallowed with a little water. No special dietary restrictions are necessary before or after treatment. The best time to take the drug is after a light meal (e.g., breakfast). A mild laxative may be desirable in constipated patients to achieve a normal bowel movement.

Young children should have the tablets crushed to a fine powder and mixed with a small amount of water to form a paste.

NICLOCIDE has a vanilla taste which is not unpleasant to most persons.

NICLOCIDE is suitable for administration on an ambulatory or outpatient basis.

4. Follow-up:

As the vermifugal action of NICLOCIDE renders the tapeworm, especially the scolex and proximal segments, vulnerable to destruction during their passage through the gut, it is not always possible to identify the scolex in stools. The sooner the tapeworm is passed and examined after treatment, the better the chance of identification of the scolex. Segments and/or ova of beef or fish tapeworm may be present in the stool for up to 3 days after therapy. Persistent *T. saginata* or *D. latum* segments and/or ova on the seventh day post therapy indicate failure. A second identical course of

treatment may be given at that time.

No patient should be considered cured unless the stool has been negative for a minimum of three months.

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recurrent anginal pain and reduced exercise tolerance associated with angina pectoris.

\*Hannemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. C., Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. R.: Digital Plethysmography For Assessing Erythrityl Tetranitrate Bioavailability. Clin Pharmacol and Ther 29:35-39, 1981.

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**INDICATIONS:** Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris rather than for the treatment of the acute attack of angina pectoris since its onset is somewhat slower than that of nitroglycerin.

**CONTRAINDICATIONS:** Idiosyncrasy to this drug.

**WARNING:** Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

**PRECAUTIONS:** Intraocular pressure is increased therefore caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.

**ADVERSE REACTIONS:** Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine and many other agents. An occasional individ-

ual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur.

### DOSAGE AND ADMINISTRATION

Oral / Sublingual Tablets. Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg. prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

### HOW SUPPLIED:

**CARDILATE** (Erythrityl Tetranitrate) TABLETS (Scored)  
for ORAL or SUBLINGUAL USE 5 mg: Bottle of 100;  
10 mg: Bottles of 100 and 1000; 15 mg: Bottle of 100

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# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This is a fifty-five year old man who sustained an acute myocardial infarction four months prior to this admission. He had an uncomplicated course. He stopped his habit of heavy cigarette smoking and began an exercise program. Two months later, after walking two miles, he developed chest pain. One month prior to this admission he developed more chest pain and chest pressure that were associated with dyspnea. He had to be hospitalized for treatment of angina and congestive heart failure. Cardiomegaly and a systolic heart murmur were present. No new myocardial infarction was diagnosed. Digoxin, furosemide and potassium chloride partially controlled his symptoms. His activities were severely limited although he was comfortable at rest. Cardiac catheterization and coronary angiography were recommended to evaluate the angina, congestive heart failure, and systolic heart murmur that developed after his myocardial infarction. This twelve lead ECG was obtained at his admission for the cardiac catheterization.*



## Questions:

### 1. The twelve lead ECG shows:

- The right and left arm leads are reversed.
- Dextrocardia.
- Inferior wall myocardial infarction.
- ST segment elevation compatible with left ventricular injury or aneurysm formation.
- Atrial enlargement.

### 2. The following statement(s) is/are true:

- Mirror image dextrocardia is almost always associated with situs inversus.

- In the adult patient, mirror image dextrocardia is rarely accompanied by any intracardiac abnormality.
- In the pediatric age group, complex congenital anomalies may be associated with mirror image dextrocardia, *i.e.* transposition of the great vessels with or without pulmonic stenosis and with or without a ventricular septal defect.
- The determination of the body situs often indicates the position of the atria.
- All of the above.

(Continued on page 168)



**BECAUSE  
A THIAZIDE ALONE  
CAN ONLY DO  
SO MUCH...**

**AND YET  
CAN DO  
TOO MUCH.**



# INCREASE CONTROL WITHOUT INCREASING POTASSIUM PROBLEMS.

## **A dependable means to long-term blood pressure control.**

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The combination of propranolol HCl, the world's most trusted beta blocker, and hydrochlorothiazide, the standard among diuretics, enables *INDERIDE* to exert an additive antihypertensive effect.<sup>1,2</sup> In fact, a propranolol/hydrochlorothiazide regimen maintained blood pressure below 90 mm Hg in 81.8% to 86.4% of patients followed for 6 to 18 months of therapy.<sup>1</sup>

## **Low thiazide dosage means reduced risk of hypokalemia.**

When thiazides are prescribed in doses greater than 50 mg/day, the potential for hypokalemia increases substantially. What's more, the greater the fall in serum K<sup>+</sup>, the greater the risk of hypokalemia-induced PVCs.<sup>3,4</sup>

With *INDERIDE*, the additive hypotensive effect of propranolol HCl allows the effective dose of hydrochlorothiazide to be kept low (25 mg b.i.d.). And by lowering the daily dose of diuretic, *INDERIDE* also lowers the potential for diuretic-induced side effects. Potassium problems are less likely to occur—yet blood pressure can be controlled consistently.



# **INDERIDE®**

Each tablet contains *INDERAL*®  
(propranolol HCl) 40 mg or 80 mg,  
and hydrochlorothiazide 25 mg

**B.I.D. 40/25  
80/25**

## **When you know you need more than a thiazide.**

Please see Brief Summary of Prescribing Information on following page.



# INDERIDE®

Each tablet contains **INDERAL®** (propranolol HCl) 40 mg or 80 mg, and hydrochlorothiazide 25 mg

**B.I.D. 40/25 80/25**



## BRIEF SUMMARY

(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

## INDERIDE®

BRAND OF  
propranolol hydrochloride  
(INDERAL®)  
and hydrochlorothiazide

No. 484—Each <b>INDERIDE®</b> 40/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	40 mg
Hydrochlorothiazide	25 mg
No. 488—Each <b>INDERIDE®</b> 80/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	80 mg
Hydrochlorothiazide	25 mg

**WARNING:** This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

**INDICATION:** **INDERIDE** is indicated in the management of hypertension. (See boxed warning.)

**CONTRAINDICATIONS:** **Propranolol hydrochloride (INDERAL®):** Propranolol hydrochloride is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

**Hydrochlorothiazide:** Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

**WARNINGS:** **Propranolol hydrochloride (INDERAL®):** **CARDIAC FAILURE:** Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuation of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA:** Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

**USE IN PREGNANCY:** **Propranolol hydrochloride (INDERAL®):** The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in

animal studies at doses about 10 times the maximum recommended human dose.

**Hydrochlorothiazide:** Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**Nursing Mothers:** Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

**PRECAUTIONS:** **Propranolol hydrochloride (INDERAL®):** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

**Hydrochlorothiazide:** Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperurcemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

**ADVERSE REACTIONS:** **Propranolol hydrochloride (INDERAL®):** **Cardiovascular:** bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

**Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

**Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

**Respiratory:** bronchospasm.

**Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**Hydrochlorothiazide:** **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

**Central Nervous System:** dizziness, vertigo, paresthesias, headache, xanthopsia.

**Hematologic:** leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

**Cardiovascular:** orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

**Hypersensitivity:** purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reaction.

**Other:** hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

**HOW SUPPLIED:**—Each hexagonal-shaped, off-white, scored **INDERIDE** 40/25 tablet is embossed with an "I" and imprinted with "INDERIDE 40/25," contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 (NDC 0046-0484-81) and 1,000 (NDC 0046-0484-91). Also in unit dose package of 100 (NDC 0046-0484-99).

—Each hexagonal-shaped, off-white, scored **INDERIDE** 80/25 tablet is embossed with an "I" and imprinted with "INDERIDE 80/25," contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 (NDC 0046-0488-81) and 1,000 (NDC 0046-0488-91). Also in unit dose package of 100 (NDC 0046-0488-99).

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# Obituaries

**Bruno, Nicholas J.**, Chicago, died July 15, 1982 at the age of 72.

**Dorfman, Albert**, Chicago, died July 27, 1982 at the age of 66. He was a graduate of the University of Chicago.

**Fields, Calvin H.**, Skokie, died July 19, 1982 at the age of 41. He was a graduate of University of Iowa College of Medicine.

**\*Furman, Jerome**, Chicago, died July 27, 1982 at the age of 77. Dr. Furman was a 1935 graduate of the University of Health Sciences/Chicago Medical School.

**\*Hull, Jack, D.**, Champaign, died July 13, 1982 at the age of 66. Dr. Hull was a 1949 graduate of the Indiana University School of Medicine.

**\*\*Hynes, Edward, J.**, Covert, Michigan, died July 9, 1982 at the age of 93. Dr. Hynes was a graduate of Milwaukee Medical College.

**\*Kesler, R. Lincoln**, Oak Park, died June 22, 1982 at the age of 74. Dr. Kesler was a 1936 graduate of Rush Medical College.

**\*\*Kirkwood, Tom**, Lawrenceville, died July 12, 1982 at the age of 93. Dr. Kirkwood was a 1912 graduate of Jefferson Medical College, Thomas Jefferson University, Philadelphia. A member of the ISMS 50 Year Club, Dr. Kirkwood had practiced medicine in Illinois since 1913. He served as president and vice-president of the Aesculapian Society of the Wabash Valley and was president of the Lawrence County Medical Society. Dr. Kirkwood was the first to receive the Lawrence County Medical Hospital "Forward Look Award" for his devotion since its opening in 1950 to the hospital where he was an active staff member as well as staff



president for several terms. He served as permanent historian for the ISMS and contributed writings to publications such as the "History of Medical Practice in Illinois."

**\*Lawler, Richard H.**, Chicago, died July 24, 1982 at the age of 87. Dr. Lawler was a 1932 graduate of the Loyola University Stritch School of Medicine.

**\*Lounsbury, B. Franklin**, Oak Park, died July 27, 1982 at the age of 70. Dr. Lounsbury was a 1939 graduate of Northwestern University Medical School.

**\*\*Mandel, Julius I.**, Chicago, died July 14, 1982 at the age of 89. Dr. Mandel was a 1918 graduate of the University of Health Sciences, Chicago Medical School.

**\*\*McClelland, Clarence E.**, Decatur, died June 27, 1982 at the age of 99. Dr. McClelland was a 1907 graduate of Northwestern University Medical School.

**Siegfried, Irving**, Chicago, died July 14, 1982 at the age of 73. Dr. Siegfried was a graduate of *Deutsche Universitat Medizinische Fakultat, Praha*.

**\*\*Smarzo, Marjorie M.**, Mt. Pleasant, N.J., died June 30, 1982 at the age of 87. Dr. Smarzo was a 1921 graduate of the Boston University School of Medicine.

**Standish, Myles**, Oak Park, died July 26, 1982 at the age of 78. Dr. Standish was a 1933 graduate of the University of Health Sciences/Chicago Medical School.

**Suttie, Grant**, De Kalb, died June 10, 1982 at the age of 71. Dr. Suttie was a 1938 graduate of University of Illinois College of Medicine, Chicago.

**\*\*Wood, Willard L.**, Chicago, died July 28, 1982 at the age of 87. Dr. Wood was a 1930 graduate of Rush Medical College, Chicago.

*\*Indicates ISMS member*

*\*\*Indicates member of the Fifty Year Club*





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1. Promoting Health/Preventing Disease: Objectives for the Nation. U.S. Department of Health and Human Services, November 1980.

\*An in vitro simulation of gastric ulcer acid level conditions based on standard laboratory methodology. Data on file. Ayerst Laboratories  
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# Medical Student Section in Action

## *New Leadership*

As this marks the beginning of a new year for most students, this column is intended to introduce the governing council of the ISMS-Medical Student Section and to share some of their thoughts. The chairman is Kurt Elward, a fourth year student at UI, Chicago. Linda Tetzlaff, a third year student at Rush Medical College, serves as vice-chairperson. Both officers will provide continuity and a solid foundation, since each sat on the governing council in other capacities during the previous term. The secretary, Don Matsunaga, is a third year student at the UI, Peoria. The delegate is Malcolm Major, a third year student at the UI, Chicago. Patrick Merrill, a third year student at the UI, Champaign, is the alternate delegate.

We hope to effectively address both the concerns of the Society and the interests of medical students. To this end we feel efforts must be made in the areas of financial aid, membership, communication, representation, and services. Kurt Elward is both informed and able to assist efforts to establish alternate programs for financial aid.

### **Financial Aid Issues**

As we are all painfully aware, financial aid is becoming more difficult to find, much less to draw upon. Next year, WHSC scholarships will be nonexistent, HPSL's and NDSL monies will be reduced and while the HEAL program remains well funded, its high interest rates put a large burden on the borrower.

Some help is on the way. The ISMS has begun to set up a loan foundation for students. Drawing upon the Education and Research Foundation, private contributions and foundation support, the ISMS hopes to be able to establish a self-sustaining loan fund within 3-5 years. Formal plans outlining the number and amount of loans, requirements, and repayment schedules have not been established. It's hoped that restrictions will be minimal, but eligibility will probably be based on senior standing and need.

For the present, however, the outlook remains less than bright. The MSS and other student groups are working at local and national levels to fight the erosion of resources. We'll do our best to keep you posted on what is developing. Meanwhile, search out any source of aid you can, and do not forget to write your congressmen. It does make a difference.

### **Membership**

Membership is a keen issue at all levels of organized medicine. Linda Tetzlaff was part of the force behind last year's drive for new members, and she will continue to strive to fulfill new objectives.

Medical students are frequently considered to be a permanently discontented lot; often their complaints revolve around the inequities they perceive in medical education and the health care system. But now, more than ever, students are



becoming vocal and active in efforts to facilitate improved health care and access, and they recognize that formation of health policy is a vital responsibility for the health care professional. One of the most effective groups for this purpose is organized medicine. Student input has been actively sought on all levels. In the past few years student membership and participation have grown tremendously. Over 800 students belong to the ISMS-MSS, and objectives have been set to continue to increase the yearly increment of new members. This participation is one of the best opportunities for students to form leadership skills and become involved in forming health policy.

It may seem simpler to sit back and let someone else research the issues and make efforts for change. But these are the issues that will clearly reflect upon you as a health professional and will directly affect most of you soon. It is worth while to take advantage of the system. You have the chance to change things you don't like and discover what organized medicine is all about first hand. Don't rely on your old notions; get involved—see if changing the future is rewarding for you.

### **Communication**

In keeping with his responsibilities as MSS secretary, Don Matsunaga is aware of the need for communication and accessibility.

One fundamental strength of an organization is the synergistic phenomenon of collective efforts. Effective communication is essential. Both this column and the JAMA Pulse have reduced the gulf between leadership and members. A survey of members is planned in order to better delineate interests, attitudes, and knowledge about the ISMS and AMA. With this information we hope to direct efforts in accord with interests and needs of the medical student. We encourage local school activities and intend to develop an educational workshop for school representatives.

Involvement is the key to MSS success. Being part of a team is rewarding and worthwhile. Accessibility is, without question, a major concern. The Society has welcomed opinion from all sectors, and we want to urge all students, members and non-members, to share their ideas with the school representatives and the governing council. We can be reached by writing the Illinois State Medical Society—Medical Student Section, 55 E. Monroe, Chicago, Illinois, 60603. It is clear that ISMS can accomplish more than any one individual, but only with good communication can the all-important assets of the individual be preserved and utilized.

### **Representation**

Effective representation is our goal. Without it we lack credibility. Malcolm Major will serve to cast the student vote at ISMS assemblies.

The purpose of the Medical Student Section on both the state and national levels is to represent medical students. Students in Illinois have been particularly successful in expressing their viewpoints at both levels. Students sit on ISMS councils and also have participated in task forces on financial aid.

Students have been successful on the state level in the adoption of many resolutions. These have ranged from seatbelt use to a new loan fund. In the coming year students will again face several pressing issues: most notably, the increasing difficulty in obtaining financial aid and the structuring of an AMA National Health Policy. Both will need student input. The bottom line is that students here have the opportunity to express themselves in organized medicine, and the work of student representation is an important goal, since it will certainly shape the future of medical practice.

### **Membership Services**

Service to medical students must be maintained, and Patrick Merrill has helped to generate a concern for local programs.

The growing ISMS Medical Student Section is becoming increasingly involved in school, community, and statewide activities concerning medical students and health care issues. Members from schools around the state are organizing guest lectures, career day seminars, and other events for students at their respective schools. Community programs such as hypertension screening have also been started. Semi-annual seminars are held for all medical students around the state. Topics for recent seminars have included alternative perspectives in medicine and a mock malpractice trial presented by actual lawyers. Services for medical students also are provided by the active voice that the MSS sustains within the ISMS.

We have been busy with these concerns over the summer and are preparing for the work ahead of us. The vistas are wide and the goals are long-term. We proceed with an optimism garnered by a sense of purpose and fueled by the help of others. At this time, when we can look back and look ahead, we thank all those individuals who have contributed their time and thoughts, and especially, the ISMS, for their fiscal help, personal counsel, and the chance to participate in the future of organized medicine. ◀



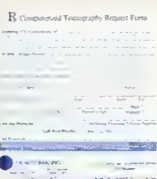
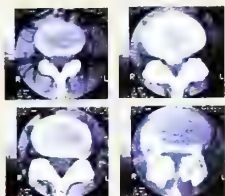
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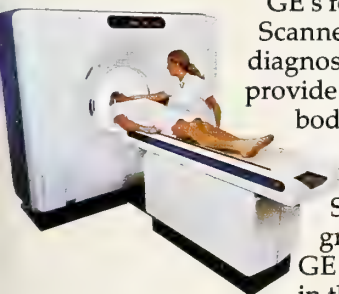
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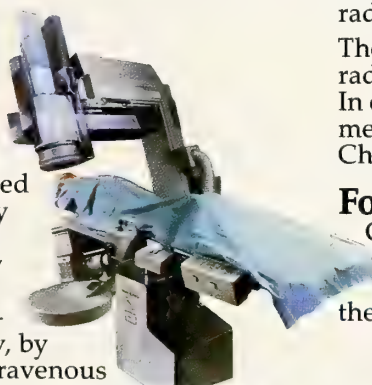
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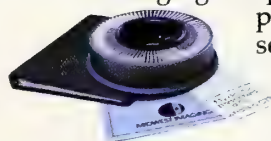
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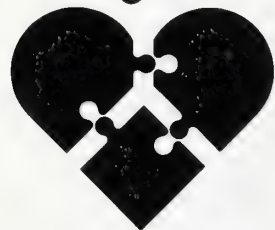
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Pregnancy Category C. Animal reproduction studies have not been conducted; whether Tuberculin, Old, TINE TEST® can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity is unknown. Tuberculin, Old, TINE TEST should be given to a pregnant woman only if clearly needed. During pregnancy, known positive reactors may demonstrate a negative response.

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## EKG

(Continued from page 155)

Answers: 1. B, C, D 2. E

The ECG at first appears to have the arm leads reversed. However, the P wave is inverted in many leads: I, AVL, and the left precordial leads. The leads are correct; the atria are reversed. The sino-atrial node is on the left side so depolarization is occurring from left to right instead of right to left. The patient also has situs inversus. Physical exam and chest X-ray showed dextrocardia. Mirror image dextrocardia is probably the most common type of dextrocardia. It can be associated with severe intracardiac anomalies that result in death. Survival to adulthood suggests the absence of these congenital anomalies. However, our patient developed acquired coronary heart disease. The ECG shows significant Q waves and ST segment elevation with T wave inversion in leads II, III, and AVF. This suggests an inferior wall myocardial infarction and left ventricular aneurysm formation. The ST segment elevation could mean acute injury but the history of myocardial infarction four months earlier makes left ventricular aneurysm more likely. Cardiac catheterization demonstrated mild pulmonary hypertension with 30 mmHg V waves in the wedge tracing. The left ventricular angiogram confirmed the presence of severe mitral regurgitation and a large posterior basal ventricular aneurysm. The coronary arteriogram showed significant proximal obstruction in the left anterior descending and obtuse marginal arteries with a totally obstructed right coronary artery. Successful surgery was performed: mitral valve replacement, aneurysm resection, and a double aorta coronary saphenous vein bypass. The patient is doing well at the one year follow-up examination.

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# Pulse of the ISMS Auxiliary

***Are You Aware . . .***

## **Smoking and Teenagers**

BY MRS. DONALD HINDERLITER, ISMSA PRESIDENT

According to the American Lung Association almost a million teenagers take up smoking every year.<sup>1</sup> Despite a very aggressive anti-smoking campaign, teen smoking is increasing. Studies have shown that most teenagers who smoke are from families where one or both parents smoke. Smoking behavior may be transmitted from generation to generation through smoking mothers and/or fathers.<sup>2</sup> Parents, then, should stop smoking not only to improve the environment in which their families live, but also for the purpose of role modeling.

Studies of young mothers of childbearing age have proven that smoking can harm the unborn fetus. In addition to having more miscarriages and stillbirths, infants of smoking mothers weigh less at birth. Unless the mother stops smoking before the fourth month of pregnancy, some untoward effect can be expected in the baby.<sup>3</sup> Also disconcerting is the finding that children whose mothers smoked during pregnancy do less well on achievement tests in math and reading at ages seven and eleven.<sup>4</sup>

The significance of maternal smoking is important not only for mothers but also for their teenage daughters. The information that smoking may harm not only their health but that of future generations may be an incentive for teenage girls not to start smoking.

Today, six million children and teenagers smoke.<sup>5</sup> Past research and experience indicate that the majority of children who begin smoking will continue to smoke regularly for life and as a result

will have a less healthy and shorter life span.<sup>6</sup>

A thorough understanding of youth, their value system, and group behavior is the foundation from which to plan teenage smoking education programs.<sup>2</sup> Knowledge does not always lead to a change in behavior but sound information is still the basis from which behavior change normally occurs.

Anti-smoking education is one good place for auxiliaries to become involved, not only by setting a "stop-smoking example" for their own families and friends, but also by becoming active in smoking education programs in their schools. This is an area to unite with the Cancer Society, the American Lung Association, or the American Heart Association and work as a coalition. These organizations have excellent information and programs which we can support. There is no need to re-invent the wheel.

More than 30 million Americans have quit smoking and 100,000 of them are doctors.<sup>1</sup> A goal we need to reach as physicians' families is the zero-smoking population.

A study of children aged 11-18 showed more sickness among those who smoked. Children who are exposed to cigarette smoke have twice the respiratory disease rate of other children.<sup>7</sup> The earlier a person begins smoking cigarettes, the greater the risk to the smoker's health in future years. As a teenager, the risk of heart attack in later life seems remote. However, even teenagers begin to develop signs of disease such as coughing,

decreased stamina, and increased heart rate.<sup>8</sup>

There are no-smoking work groups, stop-smoking clinics, and other health awareness groups that auxiliary can assist in disseminating information about this harmful habit.

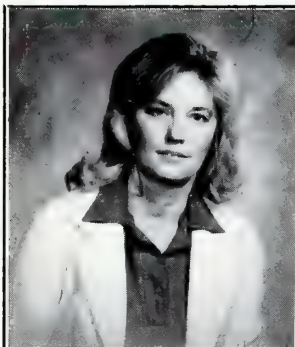
Many children and teenagers have decided to smoke, at least in part, because the only disincentive was a vague health threat many decades in the future. Students need a different approach than adults.<sup>9</sup> The advantages of not smoking outweigh those of smoking. The reasons children begin smoking need to be explored further. The pros and cons need to be offered to them in the health education programs provided so they might make capable, intelligent choices. One major problem lies in educating children BEFORE they are of the age of making the decision to smoke or not. This is where we as auxiliaries need to redouble our efforts. We can cooperate with other organizations to address this challenge in ways relevant and meaningful to children and teenagers. ◀

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# Physicians Seek

## **Thomas C. Schrepfer, M.D. Candidate for 91st District Representative**

Apparently, practicing medicine, running a farm and maintaining a family life are not enough for Thomas C. Schrepfer, M.D. Dr. Schrepfer is now campaigning hard for public office.

A lifelong Central Illinois resident, Dr. Schrepfer is seeking the Republican seat for the Illinois House of Representatives in the 91st District. The 91st District is located in Central Illinois and includes Mason County and parts of Fulton, Tazewell and Peoria counties.

Dr. Schrepfer, a family practice physician, has committed himself to an arduous profession. Nonetheless, he plans to continue practicing medicine in Havana while actively participating in politics.

A native of the Metamora area, Dr. Schrepfer received a grant from the McFarland Medical Trust Fund which assisted him through medical school. He received his M.D. degree from the University of Illinois College of Medicine in 1974. After completing his family practice residency at three hospitals in Rockford, Dr. Schrepfer began his practice in Havana in 1977.

Dr. Schrepfer is affiliated with the Havana Medical Center. He is a staff member of the Mason District Hospital, Havana, and the Graham Hospital, Canton. An ISMS member, Dr. Schrepfer also belongs to the Fulton County Medical Society and the American Academy of Family Practice. He is a founding member and past president of the Mason County Board of Health, and he continues to serve on the Board. Dr. Schrepfer belongs to the ISMS/Illinois Ag-



**Dr. Schrepfer talks to one of his patient constituents.**

ricultural Association Medical Student Loan Fund Board, which is designed to administer loan funds and recommend medical students to the University of Illinois.

In addition to his commitment to the medical profession, Dr. Schrepfer is a family man and a farmer. He and his wife, Carol, have three children. On the homefront you might find Dr. Schrepfer gardening with his family or tending to his 10 polled herefords on his small farm south of Havana.

Between his family, farm and medical practice one might wonder where politics fits into his busy schedule. Dr. Schrepfer responds to such questions by saying, "Well, it's like my dad always told me, 'If you have an important job, ask a busy man to do it. He'll get it done and get it done right the first time.' Actually, part of the problem is that most of the people who should be in the state legislature think they are too busy to do it."

# Public Office

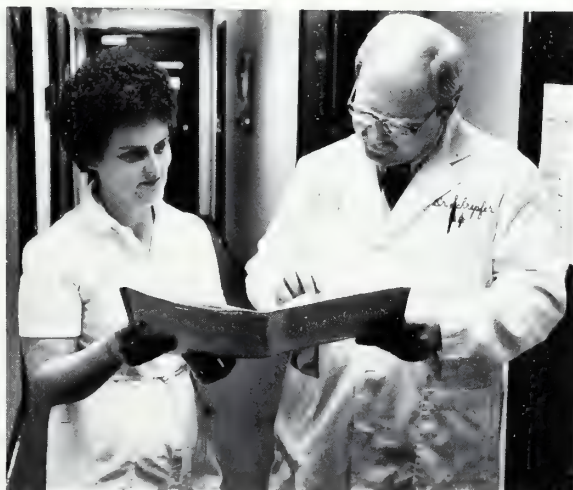
## ***James Mathis, M.D.***

### ***Seeks 115th District Seat***

One issue he believes needs attention is wasteful government spending, something Dr. Schrepfer says he will work to eliminate. In addition to government spending and, of course, health care, Dr. Schrepfer is concerned about transportation, education and unemployment.

In the past two years more than 600 jobs have been lost in Mason County. "I am determined to look at *every* bill that comes before the legislature in terms of how it will affect employment in the state," is Dr. Schrepfer's reaction to this situation.

Dr. Schrepfer has prepared for an active and hard-fought campaign. In addition to radio ads, direct mail and door-to-door campaigning which helped him to win the March primary election, television ads are expected to be a part of Dr. Schrepfer's general election campaign. Dr. Schrepfer is expecting a difficult campaign against his Democratic opponent, Thomas Homer, who beat an incumbent State Representative in the Democratic primary.



**Dr. Schrepfer vows to continue his medical practice while a legislator.**

Also running for the state legislature is James Mathis, M.D. of Sparta. Dr. Mathis is a Democrat seeking a seat in the Illinois House of Representatives from the 115th District which includes Perry and Washington Counties and parts of Monroe, Randolph and St. Claire Counties. Dr. Mathis is currently the mayor of Sparta and is opposing incumbent State Representative Ralph Dunn.

Dr. Mathis cites the condition of the economy as the major issue in his campaign, stressing that the unemployment rate in the southwestern Illinois area is at its highest level since the Depression. He maintains that the development of the coal industry and agriculture are vital to the district and that their recovery from the current recession is the key to economic stability.

A major reason for Dr. Mathis' candidacy is his deep concern for the future of medical care. He states:

"Physicians must have their point of view expressed in the legislature from a professional point of view. There is also a need for the individual physician to become politically active on the local level, whether that be in government or voluntary associations that attempt to influence health care. We must not let non-medical personnel dictate the future of medical care based on pure economics at the expense of quality."

Dr. Mathis is a 1960 graduate of the University of Illinois Medical School. Following his internship at the Illinois Central Hospital in Chicago he served in the Air Force as a Battle Group Surgeon in the 101st Airborne Division.



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# I M J

*Illinois Medical Journal*

Volume 162, No. 3, September 1982

***First Joint Venture of a State and Private Institution***

## **A Hospital Based Emergency Helicopter Service**

BY ALEXANDER J. JABLONOWSKI, M.D. AND BARBARA A. HESS, R.N./ROCKFORD

*State helicopters have been used in Illinois for more than a decade to transfer patients within the trauma center network. The first deployment of a state helicopter at a private hospital is presented. It has resulted in a cost effective quality medical service. The various problems encountered in initiating this service and their solutions are discussed.*

*This paper was first presented at the second annual conference of the American Society of Hospital Based Emergency Air Medical Services, San Diego, California, in December, 1981.*

Illinois has been in the forefront in the care and transportation of trauma victims since the early 1970s when the first trauma centers were designated. Since July, 1971, the Illinois Department of Transportation has been involved in the helicopter transport of the critically injured

or seriously ill.

In Rockford, a hospital based helicopter program has been established using an aircraft belonging to the Illinois Department of Transportation. The program has provided high quality medical care to the most seriously injured



in northern Illinois, while minimizing costs and utilizing the state helicopter more effectively.

## Background

Emergency helicopter service had its beginning during the Korean war with the evacuation of wounded soldiers from the battlefield. This method of transporting the injured was developed further in Viet Nam, where no soldier was more than 35 minutes away from definitive care.<sup>1</sup>

The civilian application of the military model was initiated in Ohio in the late 1960s<sup>2</sup> and has been refined since Denver initiated its "Flight for Life" helicopter program in 1972.<sup>3</sup>

However, with the prevailing economic situation, not all hospitals are able to afford and support a helicopter program. Private institutions are faced with large costs in leasing or purchasing aircraft. It is often difficult to show that the program will be cost effective. In most instances, the costs are prohibitive.

In Illinois, the number of trauma victim helicopter transfers has been increasing since 1971. In northern Illinois there was a need to more efficiently move these patients within the trauma center network.

Prior to its deployment to Rockford, the state helicopter serving northern Illinois was based at a less than easily accessible site on the outskirts of Chicago. The position of this helicopter, even though located geographically between the two largest cities in the state, was not convenient for maximum utilization in trauma transfers.

Most long distance transfers occurring in the north central portion of the state are made either to one of the three Rockford hospitals, or from a local hospital in the nine-county region of northwestern Illinois to one of the tertiary care centers in the Chicago area.<sup>4</sup> Because of the delays in activating the previous helicopter system, and because of the distances involved, it was easier and often faster to transfer the patient by ground ambulance to the receiving hospital.

Another problem involved the nurse who accompanied the patient. When the helicopter landed at the receiving hospital, its mission was over, and the aircraft returned to its base. This stranded the nurse along with the medical equipment in another city. The nurse had to find her own transportation back to the hospital of origin.

By moving the state helicopter from Elgin to Rockford, adjacent to the trauma center, the slow response time, which had been as much as 90 minutes, was reduced to ten minutes or less. Since the trauma center now provides the nurses and medical equipment, the problem of the stranded nurse was resolved because the helicopter, flight

crew, and medical equipment always returned to the trauma center.

## Discussion

*Flight Nurse*—Patients have benefitted not only because of the increased utilization of the aircraft and the rapid response times, but also because of the selection and training of highly qualified flight nurses. These nurses have been chosen for their education, experience in critical care units, and ability to work under stress. They are required to complete the trauma nurse specialist and advanced cardiac life support courses. In addition, they must take an exam based on the advanced trauma life support course, must demonstrate their skill in endotracheal intubation, and must attend a week-long course on aeromedical transportation, altitude physiology, and aircraft safety given by the hospital. They must keep current a perfect CPR strip and pass a physical examination based on Federal Aviation Administration (FAA) guidelines.

Because of this consistent, experienced, highly-qualified nursing care in flight, patients benefit during the short time they are between hospital environments.

*Designation.* The helicopter was repositioned to Rockford because of the city's central location in northern Illinois. St. Anthony Hospital Medical Center already served as the regional burn unit and regional trauma center. It also had an excellent location and facilities available for the construction of the hangar and fuel farm and was therefore the logical choice. Repositioning of the helicopter to Rockford came about because of the mutual cooperation of hospital administration, several state officials, and area legislators.

The hangar site is adjacent to the trauma center and is connected to it by a glass-enclosed brightly lit walkway. In inclement weather, the helicopter lands on a special transporter which brings the aircraft into the hangar. When the overhead door is closed and the patient transferred to a cart, the patient is only twenty steps away from definitive care.

## Problems

Hospital-based helicopters are a new concept and confusion as to ownership of the aircraft occasionally results. Hospital information about the program stresses that the helicopter belongs to and is operated by the Illinois Department of Transportation. The state provides the aircraft for use in critical transfers on a 24-hour a day basis. The hospital provides only the medical services.

Because the helicopter is the state's, there have

been some limitations imposed that would not be necessary if the helicopter were leased. Under the system, only the most seriously ill or critically injured patients qualify for transport, and then only to higher levels of care. The program does not handle lateral patient transfers. There have been no scene transfers since the helicopter was moved to Rockford, but the program has participated in disaster drills where victims have been transferred from the scene. The program does not interrupt the traditional referral pattern to the hospitals in Illinois. Currently, 55% of the helicopter transfers terminate at St. Anthony Hospital Medical Center.

There are some private helicopter services located on the fringes of our service area. The program respects their right to do business, and encourages hospitals in their service area to utilize their services.

There was a pre-existing private air ambulance service in Rockford prior to the repositioning of the state helicopter. Before the helicopter was moved to Rockford, the owner of this service sent a letter to the state noting that he welcomed this added resource.

The helicopter was initially purchased for engineering, law enforcement, and executive flight requirements. It continues to be used to satisfy those requirements, but its first priority is trauma patient transfers. These executive flights are usually of short duration, and previously the flight nurse and medical equipment were not on the flight. Since almost all executive flights have an empty seat, the flight nurse now goes along, and the medical equipment is stored in the baggage compartment. In the event of a trauma transfer, the helicopter lands to let off the official, and the aircraft immediately proceeds to the transferring hospital.

Maintenance has caused some small problems. The routine maintenance is done by the pilots on site, but scheduled maintenance is done in Springfield. A backup helicopter is available from Peoria, but it requires approximately 90 minutes' response time to Rockford. Fortunately there have been few mechanical problems with this aircraft, and the out-of-region time has been minimal.

Finally, communication is maintained with the helicopter over the MERCI radio frequency when the aircraft is flying in the area. The ability to communicate varies depending on the distance and altitude of the aircraft and the local weather conditions. When the helicopter is out of MERCI radio range, communication is maintained through the Springfield communication center.

The aircraft, therefore, is never unreachable.

### Benefits to the Hospital

There are certain benefits of a hospital-based emergency helicopter service that uses a state helicopter. The state provides, at no expense to the hospital or patient, the use of the helicopter, pilots, and fuel. The state also takes care of many of the administrative duties required in the operation of the helicopter service. This allows the hospital to use its funds for hangar construction, the fuel farm, and medical equipment. The end result is better patient care because the hospital can direct all its efforts to that end.

In addition, the Illinois Department of Transportation does heliport surveys for hospitals within the state, and it gives cost estimates for installation of these heliports. This service is provided by the Division of Aeronautics using experienced pilots familiar with Department of Transportation heliport regulations and FAA recommendations.

### Conclusion

There is a need for a hospital-based helicopter service in northern Illinois. The program has met that need, providing quality medical care in a cost efficient manner. Preliminary results show a decrease in morbidity and mortality as compared with other forms of transportation. The program is documenting survival rates, using the injury severity score, the trauma score, and the Glasgow coma scale. Within the next year or two, sufficient data should be available to determine how much residents of northern Illinois have benefited from this service. ◀



**BARBARA A. HESS, R.N.**, is a trauma nurse specialist and director for the Lifeline Emergency Helicopter at St. Anthony Hospital Medical Center, Rockford. Certified by the American Association of Critical Care Nurses. Hess is regional nurse coordinator and program director for Lifeline Emergency Services. She is a member of both the National Flight Nurse Association and the American Association of Critical Care Nurses.



**ALEXANDER J. JABLONOWSKI, M.D.**, is a board eligible emergency medicine physician and director of the emergency department affiliated with St. Anthony Hospital Medical Center, Rockford. A member of the board of directors and treasurer for the hospital, he is a clinical assistant professor in the department of family medicine, division of medical jurisprudence, Chi-



cago Medical School and lecturer for the department of surgery at the UI College of Medicine at Rockford. Dr. Jablonowski is medical director for the lifeline emergency helicopter as well as director of the regional trauma center. He serves as a member of the hospital executive committee and chairman of the emergency medical services committee.

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## Review of Two Prosthetic Implants

# Surgical Treatment of Erectile Failure

BY IBRAHIM S. HAWATMEH, M.D., ERIK HOUTTUIN, M.D., PHD., JOHN G. GREGORY, M.D.  
AND MICHAELA H. PURCELL, B.S., R.N./ST. LOUIS, MISSOURI

*Since 1974 two types of penile prosthetic implants have been used at our institution to treat erectile failure. The Scott's inflatable penile prosthesis has been implanted in 102 patients and the semi-rigid Small-Carrion prosthesis has been implanted in 19 patients. The percentage of surgical success is 94% and 84% respectively. The inflatable penile prosthesis is the more patient preferred method of surgical management. Past obstacles to third party payment have been reduced and prosthetic implants are affordable treatment alternatives for even the low income male.*

In the past it was believed that failure to achieve a penile erection sufficient for vaginal penetration occurred as a result of psychological trauma in 90% of cases.<sup>1</sup> However, current literature suggests that physiological disturbances may be responsible for many more cases of impotency than the 10% that was once believed.<sup>2</sup> In order for erection to occur, erectile tissue must be intact and neurovascular functions must be well integrated.<sup>3</sup> Common organic disturbances which effect these functions are diabetes mellitus, renal

failure, alcoholism, penile deformities such as Peyronie's disease, endocrine disorders, neurologic lesions and vascular disease.<sup>4-7</sup> In addition, medications such as the tranquilizers and anti-hypertensives as well as surgical procedures such as radial prostatectomy and abdominal perineal resection of the rectum have been associated to some extent with erectile failure.<sup>8-9</sup> Improved methods of diagnosis have made organic disorders that result in impotency more easily identified.

Surgical correction of erectile failure has been attempted since 1902.<sup>10</sup> Since this time various forms of semi-rigid prosthetics have been employed, and the inflatable hydraulic system has been introduced. In the past six years both methods of surgical treatment have been used at our institution. Our results in terms of surgical success and patient satisfaction are discussed.

### Methods

Since 1974, 133 males aged 26 to 73 were evaluated for erectile failure. All patients were evaluated according to the diagnostic protocol outlined in Table 1. Differentiation between psychogenic and organic impotence was accomplished by means of detailed history and physical examination as well as psychological testing and professional counseling in select cases.

Measurement of nocturnal penile erections was recorded for two consecutive nights in all subjects. In this procedure, expandable strain gauges were placed on the base and tip of the penis before the patient retired. While the patient was sleeping, changes in the penile diameter were recorded on chart paper. Occurrence or absence of erections which normally occur during REM sleep in the

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**IBRAHIM S. HAWATMEH, M.D.** is an assistant professor in the department of surgery, section of urology, St. Louis University School of Medicine. Dr. Hawatmeh is a former fellow of the Kidney Foundation of Eastern Missouri and a member of the American Federation for Clinical Research.

**ERIK HOUTTUIN, M.D.**, is a board certified urologist who serves as an assistant professor in the department of surgery, section of urology, St. Louis University School of Medicine. Certified by the Royal College of Physicians and Surgeons of Canada in general surgery, Dr. Houttuin is a former fellow of the Medical Research Council in Canada. He has also served on the medical advisory board for the Kidney Foundation of Eastern Missouri and Metro East.

**JOHN G. GREGORY, M.D.**, is a board certified urologist who is both a professor and director of the program in urology at the St. Louis University School of Medicine. A former American Urological Association Research Scholar, Dr. Gregory has received additional awards, including that from the National Institutes for Health and the Borden Prize for Research.

**MICHAELA HOY PURCELL R.N.**, is a nurse clinician in the section of urology, St. Louis University School of Medicine. Ms. Purcell is a *cum laude* graduate of Vanderbilt University and a member of the National Honor Society of Nursing.



**TABLE 1**  
**Diagnostic Protocol**  
**For the Evaluation of Impotence**

Outpatient Screening
• General history and physical examination.
• Medical history.
• Sexual history.
First Hospital Day
• Penile blood flow evaluation by Doppler ultrasound and pediatric blood pressure cuff.
• Psychological testing (optional)
• Measurement of nocturnal penile tumescence. (NPT)
Second Hospital Day
• Glucose tolerance test.
• Cystogram with concomitant electromyography of pelvic floor.
• Measurement of nocturnal tumescence.
Third Hospital Day
• Implantation of penile prosthesis.
• Detailed evaluation of blood flow for revascularization candidates.
• selective bilateral internal pudendal arteriogram
• transrectal electrical stimulation of nervi erigentes
• corpora cavernosagram

physiologically intact male was documented.<sup>11</sup> Once the diagnosis of organic impotence was established, differentiation between neurogenic and vasculogenic disturbances was made by means of the glucose tolerance test, urodynamic studies and measurements of penile blood flow. In those patients in whom surgical revascularization was planned, more detailed evaluation of the penile arterial flow and venous drainage was employed. This technique was performed on a total of five patients.<sup>12</sup> Following appropriate evaluation, 19 patients received a Small-Carrion prosthesis, 102 received the inflatable penile prosthesis, and seven were referred for psychiatric care.

## Results

In 19% of patients thought to be organically impotent the specific etiology of impotence was yet unestablished after full evaluation. However, absence of nocturnal penile tumescence suggested that physiological factors were responsible. Of the specific disorders identified, diabetes mellitus was encountered most frequently (29%). In addition, many patients had deforming Peyronie's plaques (12%). Other physiological disorders that were encountered less frequently included neurologic lesions, vascular disease, renal failure and alcoholism. In those patients who received the Small-Carrion prosthesis, follow-up has been at least one year. In patients who have received the inflatable penile prosthesis, follow-up has been at least seven months.

**TABLE 2**  
**Inflatable Penile Prosthesis**  
**Reasons for Reoperation**

<i>Possible Surgical Error—22%</i>	
Complications	Number of Reoperations
Kinks	3
Curvature	2
Infection	3
Pain	1
Total	9
<i>Possible Mechanical Failure—78%</i>	
Leak in cylinder	17
Aneurysm of cylinder	6
Leak in reservoir	6
Pump failure	3
Total	32

Failure to achieve a satisfactory result after initial surgery was seen in only one patient who received the semi-rigid rod. This patient believed that the prosthesis was too flexible. To remedy this, reinforcing flexible steel rods were placed in the prosthesis and the patient is now satisfied with the results. In 3 patients the prosthesis became infected and subsequently eroded through the penis. Two of these patients were not believed to have been optimal implant candidates. One had a previously unsuccessful implantation of an inflatable prosthesis and the other was leukemic. These erosions occurred within 27 months and 2 weeks of surgery, respectively. The third patient was lost to follow-up and the date of erosion is not known.

Collectively, surgical success is believed to be 84%. Of 16 patients with functioning prostheses, one states that his penis is too small and one that his erection is not hard enough. Overall patient satisfaction is therefore believed to be 87%.

After full explanation of both types of penile prosthetics, an overwhelming majority (84%) chose the inflatable model. All stated that the reason for this choice was the fact that the penis could remain flaccid when appropriate. Of the 102 patients who received the inflatable penile prosthesis, 33% have required reoperation to achieve a successful result. Sixty-four percent of these reoperations took place within a year of the initial surgery. Thirty percent occurred in the second year and 6% thereafter. A great majority of malfunctions discovered have resulted from mechanical failure (Table 2) which has been easily identified by means of simple radiological techniques. (Figure 1) Permanent removal of implants has been required in six patients (three because of infection, one because of pain and one because of mechanical failure). The sixth was removed at



Figure 1A

Oblique view of a functioning prosthesis showing an intact spherical reservoir; cylinder in the corpora cavernosa and the pumping device in the scrotum. No kinking, aneurysms or extravasation of dye is apparent.



Figure 1B

AP view of a non functioning inflatable prosthesis. Note large aneurysm in the mid portion of the right cylinder.

another institution for unknown reasons. Overall surgical success is therefore considered to be 94%. Seven patients have stated that they are not satisfied with the functioning prosthesis. Complaints have included ejaculatory difficulty, insufficient length, and loss of sensation in the glans penis. Total patient satisfaction is therefore considered to be 93%.

### Discussion

Because of the relatively small number of patients at our institution who have chosen the semi-rigid rod prosthesis over the inflatable model, comparison between the two prostheses is not possible in this series. However, it should be noted that others with larger patient numbers confirm our suggestion that results with both prostheses are satisfactory. Those who have reviewed results using the inflatable prosthesis have pointed out that the incidence of mechanical failure has adversely affected patient results in a number of

series.<sup>14</sup> However, it is important to consider that when one compares the results of inflatable models implanted in the early years of the prostheses with more recent results, it appears that surgical experience and mechanical adjustment have reduced the need for reoperation.<sup>15</sup> It is apparent that both the semi-rigid and the inflatable prosthesis offer acceptable treatment for impotent males. ◀

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# Office Laboratory Use by Primary Care Physicians

BY BRIAN GWARTZ, M.D. AND A. CESARE MANETTI, M.D./HOUSTON AND ROCKFORD

*Increased use of laboratory testing and rising health care costs mandate a clarification of office laboratory needs. Frequency of laboratory test requests is one index of primary care laboratory needs. Tabulation reveals a core group of tests commonly used by primary care physicians. This group includes: urinalysis, complete blood count, chemistry screening panel, strep screen, hematocrit, Pap smear and hemoglobin. Use rate is an important consideration that merits attention in order to ensure optimal laboratory design.*

The use of the office laboratory by primary care physicians has increased dramatically over the past three decades. In the late 1950s and early 1960s it was estimated that 2.2% to 7% of all physician visits resulted in laboratory requests.<sup>1</sup> This estimate increased to approximately 25% by the late 1970s.<sup>2,3</sup>

Increased laboratory use makes laboratory testing a more significant fraction of health care costs.<sup>4,5</sup> One study indicates that as many as 3.5% of patients refuse or are unable to pay for tests suggested by physicians.<sup>6</sup> As cost and use escalate, the need to evaluate office laboratory practice becomes more apparent. Such an evaluation would also provide physicians planning their own office laboratories with criteria to determine optimal space, personnel, and equipment requirements.

The literature is sprinkled with opinions about optimal laboratory design<sup>4,6-10</sup> and surveys of office testing capabilities.<sup>11,12</sup> Recommendations have been made by authorities in the field based on personal experiences.<sup>4,7,9</sup> Rarely have studies looked into tests actually performed on ambulatory patients.<sup>1,6,8,13</sup> Those that have, usually stressed the importance of categories, such as hematology and urinalysis, without mentioning the frequency of specific tests.<sup>6</sup>

The frequency of office laboratory tests requests is the most direct indicator of current laboratory practices. We felt that tabulation of laboratory requests would reveal a core group of tests constituting basic office laboratory needs. Health care costs and optimal laboratory design could then be evaluated in terms of laboratory use.

We undertook a limited investigation on the frequency of office laboratory test requests in four primary care settings to determine the core of tests which constitute basic office laboratory needs. Our methods are described below.

## Tests

An office laboratory test was defined as a laboratory examination requested by a physician during an ambulatory patient office visit. All requests for laboratory work on office patients were counted, irrespective of whether or not they were done on the premises. Patients referred to outside laboratories for sample collecting were included as long as they remained outpatients. Hospitalized patients were not included. Tests requested in the office but sent to reference laboratories for analysis were also included. Hospital pre-admission laboratory work was included if ordered in the office

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**Brian Gwartz, M.D.**, is a resident physician in internal medicine at Hermann Hospital, Houston, Texas. A former student publisher and current member of the editorial advisory board for the *New Physician*, Dr. Gwartz was a medical student at the University of Illinois Rockford School of Medicine at this writing.

**A. Cesare Manetti, M.D.**, is an associate clinical professor of pathology at the University of Illinois Rockford School of Medicine. A board certified anatomical and clinical pathologist, Dr. Manetti is in private practice and is affiliated with Swedish American Hospital, Rockford.

**Table 1**  
**Patient Visits Resulting in Laboratory Requests**

	Office				
	I	II	III	IV	Total
<b>Total Patients</b>	1044	698	2810	378	4930
<b>Total Patient Visits</b>	1382	963	3203	378	5926
<b>Total Tests</b>	548	299	1219	195	2261
<b>Total Visits With Lab Work</b>	434	232	697	136	1499
<b>Percent Visits With Lab Work</b>	31.4	24.1	21.8	36.0	25.3

and done prior to hospital admission.

The types of tests included all chemistry, hematology, serology, and microbiology. Also included were electrocardiograms and vaginal cytology smears. X-rays were excluded.

### Offices

Data were collected at four primary care physician offices within a 20 mile radius. Two of the centers are located in predominately rural areas; two are in an urban area. Offices I and II consist of multiphysician, primary care specialists (including family practitioners, pediatricians, and general internists). These are academic institutions where medical students are taught principles and practice of primary, ambulatory care. The M.D. preceptors approve all laboratory requests. The offices operate on a fee-for-service basis. Both offices have on-premises laboratories with capabilities in chemistry, hematology, microbiology, and urinalysis. Both offices send work to off-premises, commercial pathology laboratories.

Office III is a three year family practice residency training program with twelve residents in each of the years. The residents initiate their own laboratory test requests. The on-premises laboratory has capabilities in chemistry, hematology, microbiology and urinalysis. Some work is sent to off-premises, commercial pathology laboratories.

The physician in Office IV is a primary care specialist in solo practice. He is on the faculty of a medical school but precepts no students in his office. Laboratory work is performed in the office or patients are sent to a laboratory facility in the building, which serves several physicians.

### Procedures

Data from Offices I and II were collected from billing copies. Data from Office III were obtained from the computerized billing system. These data

were collected for the month of June, 1979. Data from Office IV were recorded by office personnel as the tests were ordered during the period July 10 to July 31, 1979. Analysis was performed to determine total office visits, total visits with laboratory studies, and number and kinds of tests per visit.

### Results

Between 21.8% and 36.0% of patient visits resulted in laboratory requests (Table 1). Fifty-seven different types of tests were ordered and seven of these made up 66.2% of the total number.

The complete urinalysis heads the list of the seven most commonly ordered tests (Table 2) accounting for 19.7% of the total. It is followed by the Complete Blood Count (CBC) which makes up 12% of the total. The Chemistry 24 screening panel (Chem 24), which accounts for 8.7% of the tests, is the only chemistry study in the seven most frequently ordered tests group. The strep screen and the pap smear account for 7.8% and 5.6% respectively.

Eleven other tests (Table 3) make up 26.2% of the total. These tests each make up between 2% and 4% of the total. Thirty-nine miscellaneous tests account for 7.4% of the total. Individual tests in this group each received less than 1% of the total requests.

### Discussion

The seven tests that make up the majority of requests can be easily offered in an office laboratory setting. Of these, the Pap smear and the Chem 24 are routinely sent to off-premises laboratories. The remaining five tests can definitely be considered for performance in the office laboratory.

The complete urinalysis is not only the most frequently requested test, but probably the most easily performed. A microscope, dipsticks, a hydrometer, a centrifuge, glass slides and a sink are



**Table 2**  
**Most Frequently Requested Tests**

Test		Office				Total Tests
		I	II	III	IV	
Urinalysis	# of tests	122	76	206	41	445
	% of total	(22.3%)	(25.4%)	(16.9%)	(21.0%)	(19.7%)
CBC	# of tests	51	19	161	40	271
	% of total	(9.3%)	(6.4%)	(13.2%)	(20.5%)	(12.0%)
Chem 24	# of tests	22	33	123	20	198
	% of total	(4.0%)	(11.0%)	(10.1%)	(10.3%)	(8.7%)
Strep screen	# of tests	48	34	95	0	177
	% of total	(8.8%)	(11.4%)	(7.8%)		(7.8%)
Hct	# of tests	63	28	66	0	157
	% of total	(11.5%)	(9.4%)	(5.4%)		(6.9%)
Pap smear	# of tests	43	24	50	0	127
	% of total	(7.8%)	(8.0%)	(4.1%)		(5.6%)
Hgb	# of tests	21	6	66	32	125
	% of total	(3.8%)	(2.0%)	(5.4%)	(16.4%)	(5.5%)
Office	# of tests	370	220	767	133	1500
Total	% of total	(67.5%)	(73.6%)	(62.9%)	(68.2%)	(66.2%)

all the equipment that is needed.

The CBC, the second most frequently requested test, requires a microscope, a hemoglobino-meter, a microhematocrit centrifuge, a staining rack, some glassware, and a hand counter. Specialized automated hematology equipment is worth considering since the CBC and two of its components, the hemoglobin and hematocrit, total 24.4% of all laboratory test requests.

The decision to add capability for the strep screen is perhaps the most difficult. Although it is needed relatively frequently in a primary care setting, the results are not available immediately, and therefore do not affect immediate therapeutic decisions. In addition to culture plates, an incubator and a refrigerator for storage are needed.

Certain pieces of equipment can be used in performance of more than one type of test and

**Table 3**  
**Least Frequently Requested Tests**

Test	I*	Office			Total Tests
		II	III	IV	
TB/Mantoux	32(5.8)	2(0.7)	53(4.4)	0	87(3.8)
EKG	12(2.2)	2(0.7)	64(5.3)	0	78(3.4)
VDRL	18(3.3)	24(8.0)	28(2.3)	10(5.1)	70(3.1)
Blood Glu	20(3.6)	17(5.7)	19(1.6)	4(2.1)	60(2.6)
Pregnancy test	14(2.6)	6(2.0)	33(2.7)	6(3.1)	59(2.6)
Sed Rate	4(0.7)	1(0.3)	51(4.2)	2(1.0)	58(2.6)
K+	17(3.1)	3(1.0)	30(2.5)	0	50(2.2)
T <sub>3</sub> -T <sub>4</sub>	18(3.3)	4(1.3)	15(1.2)	5(2.6)	42(1.9)
Urine culture	17(3.1)	12(4.0)	6(0.5)	1(0.5)	36(1.6)
Monospot	15(2.7)	6(2.0)	13(1.1)	0	34(1.5)
Prenatal Lab	6(1.1)	0	14(1.3)	0	20(0.9)
Other	5(1.0)	2(0.7)	126(10.3)	34(17.9)	167(7.4)
Office					
Total	178(32.5)	79(26.4)	452(37.4)	62(31.8)	761(33.6)

\*number of tests, percent of total in parenthesis

their purchase is cost efficient. Since a microscope is used in both the urinalysis and the CBC (31.7% of the total tests), its purchase would be worthwhile. A centrifuge used for urinalysis can also be used for preparing serum for transport, while a special centrifuge is needed for the microhematocrit.

Other factors have to be examined in addition to the volume of tests performed. Tests resulting in a high yield of clinical information often warrant inclusion irrespective of volume. Tests which are technically simple to perform may warrant inclusion on the basis of convenience. Quality control and availability of qualified personnel are issues which merit separate consideration.

The availability and location of pathology support services is another important consideration. Close proximity of laboratory services may obviate the need for an office laboratory without inconveniencing the patient. Ease of transport of specimens sent to support laboratories must also be weighed.

## Summary

We have looked at the frequency of laboratory tests requested by primary care specialists in order to assess laboratory needs. A small group of tests constitute the majority of laboratory requests. This group includes: urinalysis, CBC, Chem 24, Strep screen, hematocrit, Pap smear, and hemoglobin. Although use rate is not the only criterion to apply when establishing an office laboratory, it can provide a starting point. ◀

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# The Physician As Malpractice Insurer

*July 1, 1982, marked the beginning of the Illinois State Medical Inter-Insurance Exchange's seventh year of existence. In that time it has established itself as the dominant physician professional liability insurance underwriter in Illinois and the sixth largest such company in the United States. To bring physicians up-to-date on the Exchange's accomplishments, IMJ presents the following interview with Clifton L. Reeder, M.D., chairman of the board of directors of Illinois State Medical Insurance Services, Inc. (ISMIS), the Exchange's management company, and Paul E. Singer, ISMIS president.*

**IMJ:** I suppose we should begin with an historical perspective. Can you describe what contributed to professional liability insurance as a major form of coverage and the factors leading to the escalation of malpractice litigation in the mid 70's?

**Dr. Reeder:** (Laughs) You want me to write a book on that one? Actually, professional liability insurance has always been available—at least as long as I have been familiar with the insurance industry. However, in years past, it was not much of a problem because there were only a few claims, with most of those generally settled for very reasonable amounts. For many years, premiums for professional liability coverage were nominal. I can remember some physicians saying they paid 10 or 20 dollars a year.

**Mr. Singer:** And that was for "large limits"—perhaps \$5000.

**Dr. Reeder:** That was a big policy in those days. But, since then, what's happened is that—at least in my way of thinking—attorneys began to look for things to do and they found the product liability field. They began to get some fairly sizeable awards. Then the lawyers started looking at the malpractice situation.

One of the things that resulted was some deterioration in doctor/patient relationships. Years ago, doctors spent a lot of time with patients and had very personal relationships. As the science of medicine increased, the

art of medicine decreased. It seems to me that this has been a contributing factor to the professional liability problem.

In the early 70's the climate worsened and there were more suits and claims filed. 1975 was the year of the first "crisis" when a great many claims were filed. However, Dr. Leonard Berlin won a countersuit against a non-meritorious claim, and although he subsequently lost on appeal, there was a marked slowdown in the filing of malpractice claims during the time that it was up on appeal.

**IMJ:** What part was the Illinois State Medical Society playing during these years?

**Dr. Reeder:** What happened with the State Medical Society is that ISMS sponsored for its members a professional liability program underwritten by commercial insurers. In 1972, the Hartford offered a broader program than what was in place and so the Society then sponsored that program. However, I believe it was late in 1975 when Hartford, recognizing the trend in claims, asked for a large increase in premium.

**Mr. Singer:** Actually, Hartford had taken a very large increase in mid-1975—about 70%—and then proposed a 280% hike on top of that for July of 1976.

**Dr. Reeder:** That prompted the

ISMS Insurance Committee to start considering alternatives for insurance.

**IMJ:** Was ISMS the first medical society to start its own insurance company?

**Dr. Reeder:** I believe there had been two or three physician-owned insurance companies formed by that time; and they provided a model for our Insurance Committee which studied the situation.

**Mr. Singer:** The Insurance Committee initially referred to the formation of this physician-owned company as a "life boat." The Committee first attempted to negotiate a more reasonable premium proposal with the Hartford. Failing in this effort, it then attempted to find another carrier to take over the sponsored plan. It was only after both of these approaches had failed that the trigger was pulled to activate the reciprocal which had been on the drawing board.

**IMJ:** Now that we have the Exchange, there is some guarantee that at least Exchange policyholders will be safely covered if there is another escalation of the kind we saw in 1975. But is there anything to prevent exactly the same kind of thing from happening again for those people who are insured through the commercial

carriers? Would they see exactly the same scenario if the Exchange were for some reason to become less competitive and less able to provide an alternative?

**Dr. Reeder:** Well, number one, we don't anticipate that the Exchange will become less competitive. We expect that the Exchange will be in business, offering a quality product at the lowest possible price, throughout the foreseeable future. I also don't anticipate any major "crisis." We have seen increased frequency of claims right along. As a matter of fact, our filings are higher than they were in 1975 and we certainly are not in a crisis. Our company is very solvent and we anticipate keeping it solvent.

**Mr. Singer:** To some extent, crisis is a matter of perception. The 1975 crisis was one of cost and availability more than anything else, and I suppose that such a thing could occur again with respect to the commercial carriers, but the impact on Illinois should be relatively light because we would expect the Exchange to remain in business. Nonetheless, increasing patterns of claim frequency and size

of judgements have been continuing without remission throughout this period and, as nearly as we can tell, they will continue. During the six years we've been in business the average cost per doctor per year in Illinois has about tripled.

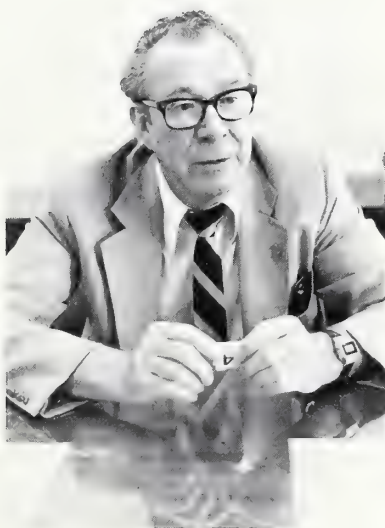
**IMJ:** *What exactly is the relationship between the Illinois State Medical Society, Illinois State Medical Insurance Services and Illinois State Medical Inter-Insurance Exchange?*

**Mr. Singer:** The Exchange is the actual insurance company. It was established as a reciprocal company which by legal definition consists solely of its members. A reciprocal typically does not have any employees or any staff, but hires a management company of some kind to run the business for the members. The Exchange's management company is Illinois State Medical Insurance Services, which is a wholly-owned subsidiary of ISMS. Insurance Services was granted a five-year contract by the Board of the Exchange to manage the Exchange for its members. That contract is renewable annually and is now in its seventh year. The Board of the Exchange is elected

by the policyholders. The Board of Insurance Services is elected by the trustees of the Medical Society. The relationship between the Exchange and the Society is merely that the Exchange pulls its membership only from the Society. There is no direct relationship between the Society and the Exchange or between the ISMS Board of Trustees and the Exchange Board of Governors.

**IMJ:** *Do you think it would be fair to say that the interaction and the shared policy-making duties give an additional perspective to the Board of Governors of the Exchange and perhaps a better picture of medical-legal or other professional implications that commercial carrier directors would not have?*

**Mr. Singer:** All are components of organized medicine in the State of Illinois, and we all work together in representing the medical profession in Illinois. Insurance Services and the Medical Society share many common facilities and services in the course of their operations. The Society supports activities of the Exchange and Insurance Services and vice versa.



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***"From the time the Exchange was formed . . . we felt that physician participation was a must . . . we felt that the physician should have a say-so in the settlement of the claim filed against him . . . If he wants that claim fought all the way up to the United States Supreme Court, we will fight it all the way up to the United States Supreme Court."***

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**—Clifton L. Reeder, M.D.**



**IMJ:** *The medical society has gone to bat for professional liability concerns in just about every session of the legislature. Do the commercial carriers provide that kind of backup to support their insureds?*

**Mr. Singer:** Commercial carriers primarily react to bills introduced in the legislature which might affect their business. They rarely have bills introduced on their own such as the Medical Society generated to try to get a handle on the claim problem.

**IMJ:** *Does a physician-owned insurer have to lobby?*

**Dr. Reeder:** Definitely. For example, there was one bill in this session that would have mandated that interest on a malpractice judgment accrue from the time of the alleged occurrence rather than the time of adjudication. Since it takes an average of six years for something to come to trial and judgment after the occurrence, there could be an increase of up to 66% in the final judgment. The bill was supported vigorously by the Trial Lawyers Association because attorneys get a cut—usually a third of any judgment. Fortunately, we were able to successfully defeat that legislation.

**IMJ:** *The Exchange claims to sell only malpractice coverage. It doesn't spend time and money on fire insurance and auto insurance and things of that type. At the same time, some of the competitors are saying that they are able to sell the other types of insurance and yet provide a cheaper premium. Can you explain that?*

**Dr. Reeder:** The Exchange was created to offer the members of the State Medical Society professional liability coverage. There are probably 1,000 to 1,500 property and casualty insurance companies in the United States which offer all kinds of coverages to the citizens of the United States. We have believed from the very beginning that the Exchange should concentrate totally on professional liability insurance. By becoming, in effect, a specialist in that product line, we felt that we would best serve our members.

**IMJ:** *We keep hearing about the advantages of a physician-owned company. But does the individual physician really have an opportunity to involve himself in the activities of the Exchange?*

**Dr. Reeder:** Of course.

**IMJ:** *How can a physician member of the Exchange participate in policy-making decisions?*

**Mr. Singer:** All policies of the Exchange are, in accordance with its rules and regulations, set by its Board of Governors. So, an obviously effective way to play a role would be to become a Governor of the Exchange. The obvious way to achieve this would be to become active in organized medicine, make yourself known to your colleagues and become a likely nominee for a vacancy on the Board.

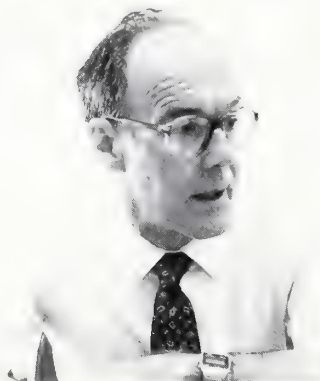
**Dr. Reeder:** Right. Become known by working your way up through the ISMS councils and the committees and House of Delegates. If you have an interest in the insurance company,

make that known to the various people, and there is a good chance that ultimately you would have an opportunity to serve on the Board of Governors.

**Mr. Singer:** In addition, there are opportunities to serve on Insurance Services committees, especially physician review committees. And, of course, any member of the Exchange who wants to express an opinion or make a suggestion, but not take on a part-time job, can write to the chairman or any governor of the Exchange or to the chairman of Insurance Services or its president and offer his comments and suggestions on how the business is being conducted. I can assure you that this correspondence is read, answered and heeded.

**IMJ:** *We understand that one of the more important aspects of physician control is that cases are not settled out of court without consent of the member physician. The Exchange has promised to go to bat for their insureds whenever there is an indefensible claim filed against one of their members. What kind of psychological advantage do you think this gives the physician in his day-to-day practice?*

**Dr. Reeder:** I would think the physician would be very comfortable with that approach. From the time the Exchange was formed and Insurance Services was set up to operate the Exchange, we felt that physician participation was a must. We wanted our members to feel that the Exchange was offering them a quality product that they would have

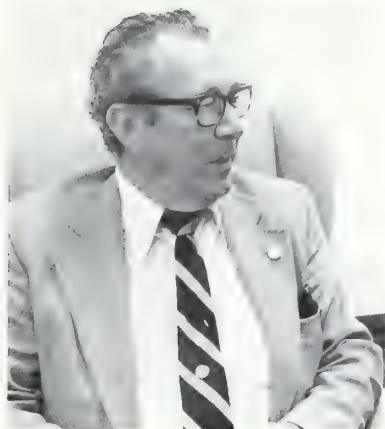


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***"The Insurance Committee initially referred to the formation of this physician-owned company as a 'life boat.' The Committee first attempted to negotiate a more reasonable premium proposal with the Hartford."***

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**—Paul E. Singer**



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—Clifton L. Reeder, M.D.

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something to say about. And we felt that the physician should have a say-so in the settlement of the claim filed against him. Sometimes there is obvious injury to a patient and something should be paid to that patient. But many other times there is no real injury to the patient and the doctor believes that he should not be penalized by having a claim against him settled. If he wants that claim fought all the way up to the United States Supreme Court, we will fight it all the way up to the United States Supreme Court.

**IMJ:** *Are there any statistics to compare the universal number of cases that are settled out of court with the rate at which the Exchange actually goes to bat for the physician?*

**Mr. Singer:** There aren't any readily available. But we can look back over the history of sponsored programs and observe over those years what fraction of the suits filed were closed with indemnity payments, what fraction were involved in legal expense and what fraction were closed without payment. The rather early indication at this point is that the Exchange is making indemnity payments on fewer claims. Of the first 1,600 or so claims that we closed, we made indemnity payments on only 20% of them.

It can be very disconcerting for a doctor to have a suit which he considers groundless turned over to his insurance company and to discover three years later, having heard nothing, that a year and a half ago the insurance company gave the patient

\$3,000 to go away and quit bothering them. This does occur with commercial carriers. It does not occur in the Exchange. We strongly believe that if the physician is not at fault, he should be vindicated.

**IMJ:** *How does Insurance Services—as the Exchange's management company—decide whether or not to accept a physician as an Exchange member? What provisions are made for renewal and nonrenewal of policies and what appeal mechanisms are available to those whose insurance is terminated?*

**Mr. Singer:** The applicant for insurance completes a six-page questionnaire which gives us virtually all the information we need to determine whether he is an insurable risk or not, but to say that he is not insurable for our purposes is not necessarily to say anything against him. There are simply some kinds of activities that we do not insure. Ordinarily, for example, we do not insure physicians whose coverage should be provided by their employer, nor do we insure full-time teachers or federally-employed doctors. Obviously, we may also choose not to insure a physician who is engaged in what we consider questionable practice activity. We have on occasion shied away from people who were deeply involved in rather ill-favored abortion mills and things of that sort.

In general, we find that most members of ISMS are insurable risks as physicians, and we insure them, but we do have the right to refuse

someone who would be likely to present us with indefensible situations and excessive costs at the expense of the other members of the Exchange.

**IMJ:** *And again, that's a physician decision?*

**Mr. Singer:** It may be an underwriting division decision. If it involves professional medical considerations, it almost certainly would be referred by the underwriting division to the medical director who may refer it to a physician review and evaluation panel. Furthermore, if the decision is made by the underwriter or by the medical director or even the physician evaluation panel, there are mechanisms for appeal of that.

**IMJ:** *I understand that there are occurrence carriers who are able to charge a lower premium and give good coverage to lower risk specialties, but they charge exorbitantly for the higher risk specialties. Would there be a problem for the Exchange if lower-risk specialists were to leave the Exchange?*

**Dr. Reeder:** Personally, I'm a great believer in competition and free enterprise. If another insurance company wants to tackle a particular segment of the market, I think that's its privilege. We certainly want to be aware of what other carriers are doing, and we will certainly give their activities serious consideration when directing future activities of the Exchange. One of our competitors is trying to select out the so-called



“cream” of the market. I don’t know how you can actually select out that cream, but if that’s their marketing strategy, so be it. Our marketing strategy is to offer the best coverage that we can offer to all members of the state medical society who qualify.

**Mr. Singer:** Actually, if we have established our rating policies correctly, our rates for anesthesiologists or neurosurgeons should suffice to support their business even if we have nothing but anesthesiologists and neurosurgeons. Indeed, if someone were to seduce away all of our Class 1 and Class 2 insureds—who represent something on the order of 60% of our members—they’d only get something like 20% of our premium volume. Ideally, any company should offer an appropriate rate for each specialty and for each classification, and each of those rates should be self-sufficient. That’s what we try to do.

**IMJ:** *With regard to the various specialties, exactly how does the Exchange classify a particular physician? And once a physician is assigned a risk category, it is permanent?*

**Mr. Singer:** Actually, we re-evaluate risk classifications every year, although we try to restrict major re-

visions to every two or three years. In fact, one thing that we did at the end of our first year was to completely revise the classification system that we had inherited from Hartford, increasing the number of classes from five to seven in order to make proper distinctions among the people who had all been lumped together in Class 5. We have made such revisions from year to year—and on a larger scale every three years—since the inception of the Exchange, in an attempt to refine the classification and rating to provide an equitable charge for every member.

**IMJ:** *Are premium surcharges part of this classification system?*

**Mr. Singer:** Yes. Although our basic criterion for classification is the physician’s specialty, we do modify his classification and rates to reflect the performance of procedures that would not normally fall into that specialty. We modify rates to reflect the number of hours worked. We provide separate premiums for paramedical employees who may be contributing to the conduct of his work and accordingly to his exposure to liability. In addition, we have provisions for surcharges on the basis of individual client records where a physician has demonstrated that he

has certain weaknesses in his methods of procedure that make him a more expensive risk.

**IMJ:** *How are these surcharges determined?*

**Mr. Singer:** All surcharges are applied on the basis of a rather detailed system which is a part of our overall filing. They are usually initiated and always reviewed by one of our Physician Review and Evaluation Panels. We have three such committees throughout the state which are responsible for determining whether a physician requires a surcharge and if so, how much or for how long a time period.

**IMJ:** *By throughout the state, do you mean they are geographically oriented?*

**Mr. Singer:** Yes. There is one for the southern half of the state, one for the northern half of the state except Cook County and one for Cook County.

**IMJ:** *What about the other side of the coin; are there premium rebates?*

**Mr. Singer:** Well, the present policy of the Board of Governors is that the redemption of the guaranty fund

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—Clifton L. Reeder, M.D.

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certificates needs to be given first priority and that all available unassigned surplus should be applied to this provision until the entire guaranty fund is redeemed. Only thereafter will we take up the practice of declaring experience dividends or premium refunds on the basis of experience. (*Editor's Note: Guaranty Fund Certificates were purchased by Exchange policyholders to establish adequate surplus for the company. Required purchase of Guaranty Fund Certificates was eliminated as of January 1980.*)

**IMJ:** *It's our understanding that quarterly rather than annual premium payments without charging interest, part-time practice discounts, premium discounts for new physicians and suspended coverage during prolonged absence are rare aspects of professional liability coverage. Are they unique to the Exchange?*

**Mr. Singer:** Well, premium payment in most commercial operations is annual, and if a quarterly installment option is provided there is a charge for it. We have designed our program around quarterly payments so that we don't have a charge built in. Reduced rates for part-time practice are relatively rare, although some commercial companies may provide some. I think the same can be said of reduced rates for physicians entering practice. Suspended coverage for absence would vary from com-

pany to company, but I think it's very rare.

**IMJ:** *We understand the Exchange offers locum tenens coverage.*

**Mr. Singer:** That's coverage for a replacement physician who handles a physician's practice while the physician is away on vacation or disabled or otherwise not practicing. It is designed for two purposes. We can provide liability insurance for the substitute physician if he does not have coverage of his own. A significant thing to our insured is that locum tenens coverage also provides insurance for him against any liability he may accrue as a result of his substitute's actions.

**IMJ:** *Isn't the Loss Prevention Education Program another activity of the Exchange that is rare among commercial insurers?*

**Dr. Reeder:** We believe loss prevention activities are very important. We believe that there are things that a doctor can do in his practice which will cut back the probability of claim, or if claim comes, help immeasurably in the defense of that claim. We want to get this information to all of our members. We recognize that there is limited time and personnel to do this. We have planned meetings for 1983 which we encourage our members to participate in. These loss prevention activities are being conducted in cooperation with the Illinois State Medical Society Com-

mittee on Loss Prevention.

We need to point out certain things that a physician can do which will improve his practice or at least his practice habits, and improving them would mean that he would be less likely to have claims filed. My feeling on loss prevention is, "let's tell our members where the losses come from, how they come about, and let's see what we can do to help them avoid the type of incident that automatically creates claims."

**IMJ:** *Where would you suggest readers go if they have additional questions about their malpractice insurance alternatives? Should they call a particular department of the Exchange, or should they contact a member of the Board of Governors?*

**Dr. Reeder:** What you are getting at, is in case some of our members are solicited for coverage by other companies?

**IMJ:** *Yes.*

**Dr. Reeder:** Well, I think the first thing that ought to happen is that an Exchange member who is solicited, if he has any questions, should call one of our policyholder services counselors. If the doctor feels he is not getting an adequate answer, he can certainly either write or call Paul or myself and we'll see that he gets the answer.

**IMJ:** *With regard to the physician review committees, do the commer-*



*cial companies in Illinois have anything like that?*

**Dr. Reeder:** Some of the commercial companies do have a medical director. Sometimes he gets involved in professional liability claims and, of course, other claims that have any medically related aspect to them. But, that particular doctor is an employee of the company and as such, he is somewhat captive to whatever the company wants him to do. In our situation, we have an independent committee of members who have opinions of their own and don't hesitate to express them.

**Mr. Singer:** The group is not simply to sit there and say: "you deserve a 30% surcharge." They will review with the physician what his problems are and how he can do something about them and make recommendations to him as to how he can improve his mode of practice.

**Dr. Reeder:** Our committees involve our members in the actual operation of the company and are tremendously important.

**IMJ:** *Is there anything to prevent any of the other carriers in Illinois from abandoning their physicians like they did in 1975 if a malpractice crisis arises again?*

**Dr. Reeder:** Every company that's in business has the right to withdraw from business in its entirety or from certain product lines if they so choose. But the Exchange was created to offer coverage to our members; the Exchange will be operated to offer that coverage and we think the operation will continue for a long, long time.

**Mr. Singer:** The Exchange must continue because we simply do not have the option that commercial carriers have of deciding to concentrate on homeowners insurance or to restrict our activities to Nevada.

**Dr. Reeder:** We have discussed at various times whether or not the Exchange should offer additional product lines. Each time we have discussed it, we have come to the conclusion that we would best serve our members by doing what we are

doing and not getting involved in other product lines.

**Mr. Singer:** We came to the conclusion for several reasons. First, because most of these product lines are already readily available to our members. They have no need of another source. Second, many of them have placed this business with agents with whom they have a longstanding relationship. They would have no reason to turn it over to us rather than to use someone who has served them well over the years. And third, it's unlikely that we could provide other coverage or service as well because we are not organized and established to perform this activity. We do not have field underwriters for property all over the state, or claim adjusters for wastebasket fires in every county. They may well be better off with the companies that they presently are with. And unless we can serve them better or at least as well, and preferably in areas where there is a need for our service, there is no point in our trying to expand.

**IMJ:** *Do the physicians of Illinois owe the Exchange any particular loyalty?*

**Dr. Reeder:** Well, physicians own the Exchange. It's their company. It's being run as their company. And we hope that they feel that it is their company. I do know that sometimes they bitch a little bit about rate increases, but when we explain how claims have increased and the cost of handling them is escalating, usually the complaints disappear.

**IMJ:** *It's been noted that a prominent commercial insurer is attempting to make inroads in the Exchange's market share by offering cheaper "claims-made" coverage. Two questions immediately come to mind. First, can you give us an explanation of the difference between claims made and the Exchange's occurrence policies? Second, what do you say to the physician who comes to you and says, "I have been approached by a commercial insurer, and my God, I could save a lot of money on that premium!"?*

**Mr. Singer:** First, occurrence coverage is the classical form of insurance which provides you insurance

for any incident that occurs while the policy is in force. If you happen not to learn of this until after the policy has expired and report it later, it is still covered. The claims-made form is one under which protection is provided for a claim that is reported while the policy is in force, if the incident giving rise to it also occurred while the policy was in force. Under that form, in order to be sure of coverage for a past incident, you must continue to maintain the policy in force or, if you allow it to lapse, you must make a separate provision for the purchase of a coverage that will provide this extension.

**IMJ:** *What about projections for the future? What trends do you see in malpractice filings? Where are the vulnerable areas?*

**Mr. Singer:** On that score, I would say that the frequency of claims seems to be increasing at about 10% a year, perhaps 11% a year. The average value of the claims seems to be increasing at something in excess of 15% a year. Recently, the combined effect is on the order of 20% or 30% a year. This is what accounts for the fact that in the six years we have been in business the average annual cost per physician has about tripled.

**IMJ:** *And how would you respond to someone who asks if claims-made coverage is cheaper?*

**Dr. Reeder:** I would tell him to go back to the claims-made company and ask them to project and then guarantee the premiums for the next five years. Then he should ask what the tail coverage will cost each year for the next five years in the event he discontinues this claims-made policy. If the insurance company refused to give me the projected premiums over the next five years, I'd be very skeptical about purchasing a contract with that company. We know that the Exchange probably will increase rates each year—we almost have to because of the increased filing of claims and increased cost of settling claims—but we believe we've got a handle on how much that's going to cost, and we probably could project reasonably close for a five-year period of time. ◀

# Rheumatology Rounds

L. F. Layfer and J. V. Jones, Contributing Co-Editors

## *Seronegative Spondyloarthropathy I*

### Ankylosing Spondylitis

A 26-year-old male was seen for low back and knee pain. One year earlier he had noted lower lumbar pain, which he related to lifting a heavy weight at work. Sciatica was not noted at that time. Warmth seemed to relieve his pain, and he noticed a gradual "loosening" of his back toward midday: calisthenics could be done in the afternoon, but not in the morning. He began to have radiation of pain to his left buttocks and occasionally to the left leg. Non-pleuritic chest pain was noted posteriorly, especially with twisting motions. Phenylbutazone was prescribed, but was stopped because of G.I. upset, although some relief of back pain was noted with its use. Pain was persistent but had been tolerable until two months before, when left knee swelling occurred and precipitated his visit.

He took no medications, had no known allergies and was without other significant past history. There was no family history of arthritis. He denied urethritis, eye irritation, venereal disease, psoriasis, mucosal ulcerations or chronic bowel dysfunction.

On examination, vital signs were unremarkable. Chest and cardiovascular examinations were unremarkable. Chest expansion was 4cm at nipple level. No rubs, rales, or murmurs were heard. Positive findings were confined to the musculoskeletal system, where a loss of extension of the lumbar spine was associated with mild flattening of the lumbar lordosis: forward flexion and lateral twisting were unimpaired but painful. Right straight leg testing was negative, hip motion was normal and peripheral reflexes and strength in

the lower extremity were intact. The right knee was warm with an effusion noted, and had moderate limitation of motion.

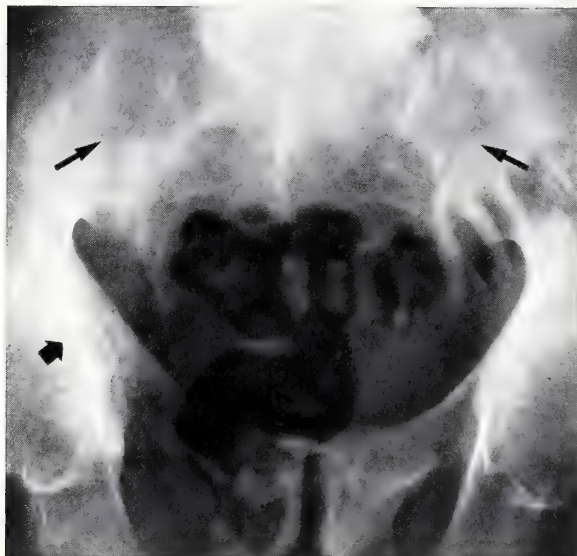
#### Laboratory

SMA-18, complete blood count, electrocardiogram, urinalysis and chest X-ray were unremarkable. Rheumatoid factor, and antinuclear antibodies were absent, complement levels were normal and sedimentation rate was 30mm/hr (Westergren). HLA-B27 was positive. Synovial fluid from the right knee showed 5000 WBC with 35% poly's, sterile culture, no crystals, good viscosity and mucin clot, and was only slightly cloudy. Knee X-ray was normal except for the joint effusion. Lumbosacral spine X-ray showed narrowed, irregular sacroiliac joints with normal lower lumbar vertebrae. EMG of the left lower extremity did not reveal a radiculopathy, and CAT scan of the lumbar spine revealed no disc herniations.

#### Discussion

Ankylosing Spondylitis (latin: Bent Vertebrae) is an ancient disease found in egyptian mummies over 7000 years old. Only recently has it ceased to be called "rheumatoid spondylitis," in allusion to it's previous status as a rheumatoid variant, and acquired enough clinical, pathologic and laboratory differences to warrant its own classification. Generally beginning in the second to fourth-decade, inflammation in the sacroiliac (SI) joint and lower lumbar vertebrae lead to low back pain, the hall mark of ankylosing spondylitis (AS).





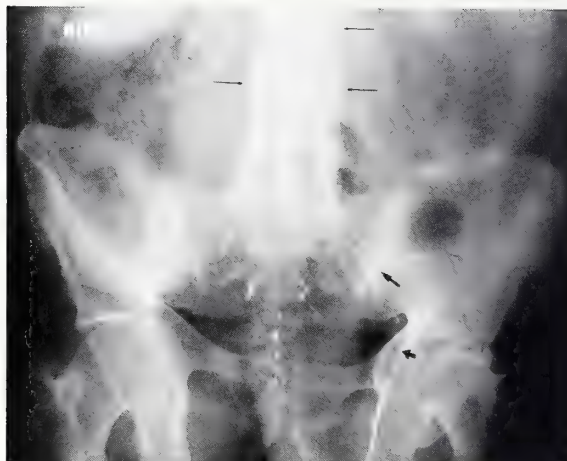
**Figure 1**

SI joint fusion is demonstrated: no joint line can be seen (thin arrows). Also note severe narrowing of hip joint (short arrow).

The character of the pain can often be distinguished from that of mechanical back pain by a morning stiffness which improves with heat and use, and worsens with inactivity. Buttock pain is common, due to inflammation of SI or hip joints, or by irritation of the sciatic nerve in the area, and may mimic sciatica from a herniated disc. Variable degrees of ascension of disease to the cervicothoracic areas occur, causing pain and stiffness.

Synovitis is the cause of inflammation in the SI and spinal apophyseal joints, but inflammation also occurs at the insertion of ligaments and capsules like the anterior spinal ligament and the annulus fibrositis (enthesopathy). Different than rheumatoid arthritis (RA), such inflammation leads to the development of fibrous scar and eventual ossification rather than destruction and erosion. X-rays reflect this, with SI narrowing and erosion leading ultimately to fusion (Figure 1). In the vertebrae, calcification of the annulus and spinal ligaments lead to bridges of bone (syndesmophytes) connecting each vertebrae, clearly distinguishable from degenerative osteophytes (Figures 2 & 3). When diffuse, it resembles a "bamboo pole," a rigid, inflexible structure unable to bend or rotate.

Findings on examination will depend upon what stage of progression the disease is in. Early, typical low back pain and stiffness and a bone scan positive for SI joint uptake may be the only clues available. As more spine becomes involved



**Figure 2**

Bony bridges (syndesmophytes), are seen connecting lumbar vertebrae (thin arrows). Also note destroyed SI and hip joints.

and fusion develops, loss of motion in all directions, straightening of the lumbar curvature, worsening of thoracic kyphosis and a neck fused in flexion become progressively more obvious and complete the typical clinical picture of the "bent vertebrae."

Peripheral joints may also be involved with inflammation, most commonly hips, knees or shoulders. Small joints of hands and feet are only rarely involved. Unlike RA, the disease is asymmetric and tends to be milder in its destructive potential. Structures like the achilles tendon or plantar fascia may become involved, causing pain and leading to calcification on X-ray. The costochondral and costovertebral joints are part of the axial disease, with rib pain and decreased chest wall motion as a result.

Systemic symptoms such as iritis, aortitis, amyloidosis and apical pulmonary fibrosis may occur. Spinal fracture, heralded by increased mobility in a fused spine, may occur even after minor trauma and is due to the weaker bone found in this disease. A curious fibrosis of the arachnoid near the sacral plexus may lead to a "cauda equina" syndrome of bowel and bladder dysfunction. Slippage of the atlas on the axis may occur secondary to ligamentous laxity similar to that seen in RA and may cause cervical cord compression. Erosion of vertebral end plates may occur for unknown reasons, and may mimic a "septic discitis" on X-ray.

Therapy consists of nonsteroidal anti-inflammatory agents, especially indomethacin. These aid stiffness and pain but are not proved to slow disease progression. Remitting agents used in RA,



**Figure 3**

Thin syndesmophytes are noted between thoracic vertebrae (arrow).

such as gold, D-penicillamine or cytotoxic agents, have not clearly been shown to cause remission of AS, but anecdotal evidence suggests their use in severe cases. Most important is physical therapy, especially postural training to aid in spinal mobility and if fusion occurs, to lead to less permanent thoracic and cervical khyphosis. Radiation therapy, an historical treatment for AS, is no longer in use due to the development of hematologic malignancies following its application.

Rheumatoid factor and antinuclear antibodies are absent in AS and sedimentation rates are normal. The striking laboratory abnormality in AS has been the presence of HLA-B27, one of the histo-compatibility antigens in man. Found normally in 5% of the caucasian population in the USA, it is present in over 90% of patients with AS. In 20% of B27 patients in such a population, some manifestation of inflammatory back disease can be found, both on X-ray and by clinical

symptoms. What such studies have revealed is that many patients have only SI disease and do not progress to the full "bamboo spine," and that most such patients who do progress are males. It must be stressed that as the HLA-B27 gene is not present in up to 10% of patients with AS, and that 80% of people with HLA-B27 gene have no evidence of spondylitis, it is of no use for diagnosis in an individual patient. In addition, the gene presence in both health and disease may vary for each different population studied.

Finally, spondylitis similar to ankylosing spondylitis may be found in several other rheumatic diseases: Reiters syndrome, psoriatic arthritis, Yersinia arthritis, and arthritis associated with inflammatory bowel disease. When present, it is often milder than AS, more confined to the SI and lower lumbar spine with fewer syndesmophytes. Some patients may progress to the full bamboo spine, however. HLA-B27 is highly associated with the spondylitis in each of these diseases. The combination of spondylitis with a rheumatoid factor negative asymmetric peripheral arthritis has led labeling of these diseases as the seronegative spondylo-arthropathies. They will be discussed in the next few installments of this column.

### Conclusion

Based on clinical, laboratory and X-ray findings, ankylosing spondylitis was diagnosed as the cause of the patient's low back pain. No evidence for a herniated disc could be found. His chest symptoms were suspected to be the costovertebral joint involvement, and his knee symptoms were thought secondary to the peripheral joint disease of ankylosing spondylitis. His knee was injected with lcc aristospan and lcc xylocaine, and he was begun on indomethacin, 50mg q.i.d., with a good response. Postural exercises were taught, and he has continued these on a chronic basis. At three month follow-up, his knee remained asymptomatic and without evidence of inflammation on examination, and he reported his back pain as markedly improved. Indomethacin was reduced to 50mg t.i.d. with no change in his symptoms, and will be maintained at that level indefinitely. ◀

### References

A complete list of references for "Ankylosing Spondylitis," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago IL 60603.



## Viewbox

(Continued from page 146)

### DIAGNOSIS: NON-HODGKIN LYMPHOMA

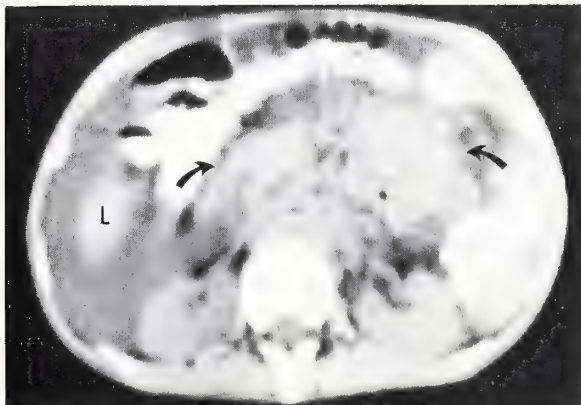


Figure 3.

CT at level of tip of right lobe of liver (L) surrounded by ascites. Massive adenopathy (arrows) displaces opacified gut.

In Figures 1 and 2 there is primarily dilation of the small bowel plus several nodular filling defects. Whipple disease may occasionally be associated with multiple small nodules, and enlarged lymph nodes may cause larger nodular defects in rare cases, but Whipple disease seldom involves the distal ileum. The other choices are not associated with nodular small bowel defects.

The diagnosis of lymphoma had been considered in this patient but could not be established by small bowel biopsy. The small bowel series was regarded as suspicious for lymphoma but the CT scans demonstrated massive lymphadenopathy which was not evident clinically (Figures 3,4). This led to laparotomy and the diagnosis of histiocystic lymphoma.

Malabsorption has a myriad of causes (Table 1). Many diseases associated with malabsorption have radiographic findings on barium small bowel examination but these findings are usually non-specific. The presence of large nodules, however, should be a signal to search for neoplastic disease, especially lymphoma.

The relationship of non-Hodgkin lymphoma of the small intestine and the clinical condition of malabsorption is well known. There are, however, several controversies regarding this relationship.

In the 1960's a type of lymphoma having spe-

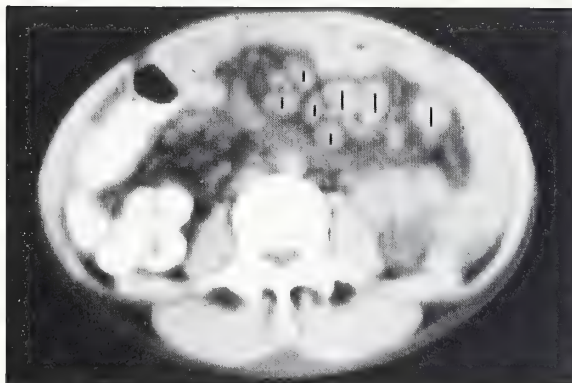


Figure 4.

CT below kidneys. Ascites surrounded mesentery containing numerous large lymph nodes.<sup>(1)</sup>

cific histologic and immunologic findings distinct from the more typical gastrointestinal non-Hodgkin lymphoma was reported. This was diffuse primary small intestinal lymphoma (DPIL) or so called "Mediterranean-type lymphoma." "Mediterranean" refers to the geographic origin of many patients with the disease. DPIL typically presents with malabsorption, unlike the non-Hodgkin gastrointestinal lymphomas in the United States and Britain which only uncommonly present with malabsorption.<sup>1</sup>

Diffuse primary intestinal lymphoma is a type of lymphoma found characteristically among non-European Jews and Arabs, South African Blacks and patients from Spain, Mexico and other Mediterranean and Central American countries. DPIL is the leading cause of malabsorption in many Middle Eastern countries and South Africa.<sup>1</sup> The high prevalence of intestinal infectious diseases and poor sanitary conditions may predispose individuals to this lymphoma. Histologically, there is diffuse infiltration of the lamina propria by plasma cells. The small intestine is diffusely involved. There is widening of the villi due to infiltration of the lamina propria by plasma cells. The epithelium retains its normal columnar shape. These findings are in contrast to the changes seen in celiac disease and the "Western" type lymphomas presenting with malabsorption where there is flattening of the villi and stunting of the epithelial cells.<sup>1</sup> In 25-50% of the cases of DPIL there is an abnormal serum IgA antibody.<sup>2</sup>

Radiologically, DPIL has several characteristic features. There is, typically, a widely disseminated infiltrative nodular pattern. The nodules are small (1-3mm) and uniform in size. Unlike the "Western" type lymphomas there is sparing of the terminal ileum despite diffuse involvement of the duodenum, jejunum and proximal ileum.<sup>2</sup> The

**TABLE I**  
**MALABSORPTION**

**Decreased Digestive Enzymes**

Pancreatic insufficiency  
Liver disease  
Bile duct obstruction

**Decreased Bowel Length**

Surgical resection  
Bypass surgery for obesity  
Fistula

**Abnormal Bowel Wall**

Sprue  
Whipple  
Amyloid  
Eosinophilic enteritis  
Crohn  
Post radiation  
Chronic ischemia  
Abetalipoproteinemia

**Lymphatic Obstruction**

Lymphangiectasia  
Lymphoma  
Carcinoid

**Bacterial Overgrowth**

Blind loop  
Afferent loop syndrome  
Small bowel diverticuli  
Stasis (hypomotility, strictures)

**Infection**

Tropical sprue  
Infectious enteritis  
Parasites

**Drug Induced**

in patients with lymphoma.<sup>4</sup>

Radiologically, any variation from the typical pattern of celiac sprue (dilated loops of small intestine, discontinuous segmented barium column, evidence of hypersecretion with dilution of barium and straightening and thinning of the mucosal folds)<sup>5</sup> should be further evaluated. The changes seen in small bowel non-Hodgkin lymphoma as described by Marshak (multiple nodules, infiltration of folds with thickening, polypoid filling defects and endo-exocentric patterns)<sup>6</sup> should be specifically sought. As seen in this case, computed tomography can prove invaluable in making the diagnosis.

The relationship of celiac disease and lymphoma is further complicated by the fact that lymphoma has developed in patients with documented celiac disease. Harris<sup>7</sup> analyzed 202 cases of celiac disease. Primary small intestine lymphoma developed in 14 patients. Eleven of these patients were on gluten-free diets and were asymptomatic. The mean duration of celiac disease in all 14 patients was 28 years.

The findings have led to statements that all small intestinal lymphomas presenting with malabsorption begin as celiac disease which is often subclinical until development of lymphoma.<sup>8</sup>

Therefore patients presenting with malabsorption, especially those with specific ethnic backgrounds, atypical barium studies or rapidly progressive symptoms, should be evaluated closely for small intestinal non-Hodgkin lymphoma. Any patients with previously controlled celiac disease who develop abrupt onset of malabsorption should also be suspected of having developed small intestinal non-Hodgkin lymphoma and evaluated accordingly. ◀

**References**

1. Gray, G., Rosenberg, S., Cooper, A., et al.: "Lymphomas Involving the Gastrointestinal Tract," *Gastroenterology* 82:143-52, 1982.
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8. Saily, R. (Ed.): "Case Records of the Massachusetts General Hospital," *N Engl J Med* 295:1242-48, 1976.

prognosis of patients with DPIL is reasonably good with favorable responses to radiotherapy.<sup>1</sup>

In patients from the United States and Britain with "Western" non-Hodgkin lymphoma, malabsorption is an uncommon presentation. In one series of 45 non-referred patients presenting with gastrointestinal lymphoma (15 of which were small intestinal) only two patients presented with prodromal symptoms of malabsorption.<sup>3</sup> As in the patient presented here, the diagnosis of celiac disease is often incorrectly made. This is due to the similar small bowel biopsy findings of villous atrophy, mucosal flattening and crypt hyperplasia in both celiac disease and non-Hodgkin lymphoma.<sup>4</sup>

Objective evidence of gluten sensitivity and the histocompatibility antigens HLA B8 and DW3 are characteristic of celiac disease and are helpful in differentiating the diseases. Transient response to gluten-free diets, however, has been reported



# Special Articles

## *The Collection and Study of Medical Antiques*

### History Through Artifact

BY IRWIN M. SIEGEL, M.D., F.A.C.S., F.I.C.S./CHICAGO

The doctor who collects medical antiques examines his professional heritage while involving himself in a meaningful exploration of medical history. This hobby combines the stimulation of historical research and the study of craft with the excitements of travel and collecting. Antique medical artifacts are often of decorative use and, occasionally, a good financial investment. But by far the greatest value of such a hobby is the insight it affords into the richness and variety of medical history. The physician collector is an expert *prop-ter hoc*. No one more than he knows the value and authenticity of the relics he assembles. Although expert reproductions of antique home furnishings have flooded the market, this is not the case with medical antiques, and except for

items which are of popular decorative value (scales, brass microscopes, etc.), medical antiques are not yet priced out of reach.

I began my collection over 12 years ago when, while browsing on vacation with my wife through several antique shops, I happened upon a Civil War surgeon's kit. What had been a diffident acquiescence to her antiquing changed overnight into an eager accompaniment, as each of us searched—she for her early American furniture and flow-blue porcelain, and I for my medical antiques. This search continues to add an interesting dimension to our travel and vacations.

Once you have two of anything, you have a collection, and cataloguing and studying these artifacts is an engaging way to learn about the history, the science, and the culture they reflect. The identification, authentication, and classification of one's collection can lead to some fascinating sources, such as old textbooks and catalogues, as well as some interesting places (I have corresponded with and visited the Smithsonian Museum in Washington and the Wellcome Medical Collection in London in order to authenticate pieces).

Medical antiques turn up almost any place medicine was practiced, and that's just about everywhere. Antique shops, antique trade journals, and occasionally auctions are the best

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**IRWIN M. SIEGEL, M.D.**, is a board certified orthopaedic surgeon affiliated with Louis A. Weiss Memorial Hospital in Chicago. He is both an associate professor in the Departments of Orthopaedic Surgery and Neurological Sciences, Rush-Presbyterian-St. Luke's Medical Center and a lecturer at the UI Abraham Lincoln School of Medicine.

sources for obtaining medical items, and there are shops (particularly in New York, Massachusetts, and Maryland) specializing in this type of antique. Antique shows, fairs and flea markets, where many dealers gather at one time, are a particularly rich source for the eager collector. The possibilities of purchasing medical antiques abroad are practically boundless. England, as you might expect, is a good place to find choice items. Although artifacts from the eighteenth century and earlier have been pretty well bought up (those still available are very expensive) many fine 19th century pieces are still to be had, and there are even categories of early twentieth-century pieces (such as pharmaceutical apparatus, or early electrical treatment machines) which are collectible. Quality and price vary, of course, but a little experience enables the physician collector to spot a good item and a good buy, and medical antiquities (like any antique) cannot help but appreciate with time.

Occasionally, one is fortunate enough to stumble upon a 'mother lode' of medical history. I did so once when I heard of a seventy year old doctor who was retiring. I told him of my interest in medical antiques and was able to purchase many of his early instruments, some handed down from his physician father. On another occasion,

I learned that a neighborhood drugstore, established over a hundred years ago, was going out of business. I attended the closing sale, told the proprietor of my interest, and he sold me a number of ancient pharmaceutical items, including apothecary jars, pill rollers, and other devices used a century ago for prescription preparation.

Medical antique collections range from the ubiquitous samples of patent medicines to the less available instruments of a given specialty. Collectible articles include bitters bottles, apothecary jars, sick feeders, pharmaceutical apparatus, surgical instruments, medicinals, therapeutic tools, gadgets, microscopes, laboratory apparatus; in fact, any objects having to do with any aspect of the practice of medicine.

Interesting information on availability and price is found in antique pricing guides, and the hobby can be enhanced by studying the medical collections housed in museums, both here and abroad, which feature cultural artifacts. Some are even devoted entirely to scientific collections (e.g., the Museum of Medical History of the International College of Surgeons in Chicago).

Collecting medical antiques is a form of material acquisitiveness that can be justified in many ways. I have shared my antiques by exhibiting them at our local historical society. The major

*(Continued on page 217)*

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# Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510, Chicago, IL 60603, (312) 236-6110.

*Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.*

## OCTOBER

### Cancer: Etiology and Prevention

**For:** Oncologists, Surgeons, Internists, Pathologists. **Symposium,** Oct. 4-6, Americana Congress Hotel, Chicago. **Speaker:** Baruch Blumberg, M.D. **Sponsor:** ITR Biomedical Research of the U of I, 115 S. Sangamon St., Chicago 60607. **Reg. limit:** 200. **Reg. deadline:** 9/15. **Fee:** yes. **Credit:** Category 1, 24 hours. **Contact:** Nancy Piekarski. **Phone:** 312/996-4688.

### General Medicine

#### Sleep Disorders

**For:** Internists, FP's, GP's. **Conference,** Oct. 18-19, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, Continuing Education, 600 S. Paulina, Chicago 60612. **Fee:** \$215. **Reg. limit:** none. **Credit:** Category 1, 6 hours. **Contact:** Barbara Trejo. **Phone:** 312/942-7095.

### Geriatrics

#### Mainstreaming the Aged Disabled

**For:** MD's. **Course,** Oct. 19-20, Chicago. **Speakers:** Henry Betts, MD; Thomas Byerts. **Sponsor:** Rehabilitation Institute of Chicago/Education and Training Center, 345 E. Superior St., Chicago. **Fee:** \$100. **Credit:** Category 1, 14 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

### Geriatrics

#### Aging and Illness in Primary Care

**For:** MD's. **Symposium,** Oct. 14-15, Madison, WI. **Sponsor:** U of WI—Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 14 hours; AOA, 14 hours; AAFP Prescribed, applied for. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

### Internal Medicine

#### Lake County Medical/Surgical Seminar

**For:** MD's. **Seminar,** Oct. 6, 8:00 a.m., Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan 60085. **Fee:** \$5. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312/578-2555.

### Medical/Legal

#### Medical/Legal Aspects of Claims for Neck/Shoulder Pain

**For:** MD's. **Lecture,** Oct. 6, Chicago. **Sponsor:** UHS/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 7½ hrs. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

### Medicine

#### Critical Care Symposium

**For:** MD's. **Lecture,** Oct. 7-10, Marriott's Lincolnshire Resort, Lincolnshire. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Reg. deadline:** 10/7. **Fee:** \$295. **Credit:** Category 1, 21 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

### Microbiology/Immunology

#### Laboratory Diagnosis

**For:** MD's. **Symposium,** Oct. 7, 1:00 p.m., Lincoln. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Cancer

#### Headache and Pain in Adults and Children

**For:** MD's. **Course,** Oct. 27, Chicago. **Sponsor:** Cleveland Clinic Educational Foundation; Bethany Methodist Hospital, 5025 N. Paulina, Chicago 60640. **Fee:** \$35. **MD:** \$15, resident. **Reg. limit:** none. **Credit:** Category 1, 6 hours; AOA, 6 hours; AAFP Prescribed, applied for. **Contact:** Administrator's Office. **Phone:** 312/271-9040.

#### Contemporary Topics in Neurology

**For:** Neurologists, Psychiatrists. **Lecture,** Oct. 25 (5 days), Chicago. **Speakers:** Frank Rubino, MD; Susan Olson, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$375. **Reg. limit:** 150. **Credit:** Category 1, 42 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

#### Specialty Review in OB/GYNE: Practical Aspects

**For:** Obstetricians, Gynecologists., **Lecture,** Oct. 11 (5½ days), Chicago. **Speaker:** M. LeRoy Sprang, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$425. **Reg. limit:** 300. **Credit:** Category 1, 45 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

#### Specialty Review in Pathology/Anatomic

**For:** Pathologists. **Lecture,** Oct. 4 (6 days), Chicago. **Speaker:** Alvin Ring, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$425. **Reg. limit:** 200. **Credit:** Category 1, 48 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

#### Liver & GI Clinico-Pathologic Conference

**For:** MD's. **Lecture,** Oct. 26, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Road, North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

#### Master Class: Ultrasound

**For:** MD's, Radiologists. **Symposium,** Oct. 22, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, Office of Continuing Education, 600 S. Paulina, Chicago 60612. **Fee:** \$115. **Reg. limit:** 200. **Credit:** Category 1, 6 hours. **Contact:** Victoria O'Sullivan. **Phone:** 312/942-7119.

#### Clinical Rheumatology

**For:** MD's. **Symposium,** Oct. 21, 1:00 p.m., Pittsfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708, Office of CME. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

#### Prostaglandin Metabolism

**For:** MD's. **Lecture,** Oct. 25, 9:00 a.m., North Chicago. **Speaker:** Nicholas Joyce-Clarke, MD. **Sponsor:** Dept. of Rheumatology, UHS/CMS, 3333 Green Bay Rd., North Chicago. **Fee:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

### Neurology

### Neurology

### OB/GYNE

### Pathology

### Pathology

### Radiology

### Rheumatology

### Rheumatology

### Stroke

#### Stroke and Neurosurgical Rehabilitation

**For:** MD's. **Course,** Oct. 12-13, Chicago. **Speaker:** Paul Kaplan, MD. **Sponsor:** The Rehabilitation Institute of Chicago, 345 E. Superior St., Chicago 60611. **Fee:** \$250. **MD:** \$175, resident. **Credit:** Category 1, 14 hours. **Contact:** Don Olson, PhD. **Phone:** 312/649-6179.

### Surgery

#### Surgical Dilemmas, Debates and Current Problems

**For:** MD's. **Symposium,** Oct. 30, Evergreen Park. **Sponsor:** Little Company of Mary Hospital, 2800 W. 95th St., Evergreen Park 60642. **Reg. deadline:** 10/22. **Fee:** \$50. **Reg. limit:** none. **Credit:** Category 1, 7 hours. **Contact:** Lois Arnold. **Phone:** 312/422-6200.

### Surgery

#### Specialty Review in General Surgery, Part I

**For:** General Surgeons. **Lecture,** Oct. 11 (11 days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$600. **Reg. limit:** 400. **Credit:** Category 1, 98 hours. **Contact:** Robert Baker. **Phone:** 312/733-2800.

### Surgery

#### Fiberoptic Esophagogastroduodenoscopy

**For:** Surgeons, Internists, Gastroenterologists. **Lecture,** Oct. 4 (2½ days), Chicago. **Speaker:** C. Thomas Bombeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Urology

#### Kidney-Testis Cancer

**For:** Urologists. **Course,** Oct. 7-9, Airport Sheraton, Indianapolis, IN. **Sponsor:** American Urological Assn., P. O. Box 25147, Houston, TX 77265. **Reg. deadline:** 10/7. **Fee:** \$230, members; \$260, non-members. **Reg. limit:** 150. **Credit:** Category 1, 16 hours. **Contact:** Alice Henderson. **Phone:** 713/790-6070.

## NOVEMBER

### Cardiology

#### Cardiac Rehabilitation

**For:** GP's, FP's, Internists. **Seminar,** Nov. 5-6, Hyatt Lincolnwood, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Drive E., Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **Contact:** Doris Price. **Phone:** 800/525-8651 x 123.

### Emergency Care

#### Emergency Department Management

**For:** MD's. **Symposium,** Nov. 18-19, Springfield. **Sponsor:** SIU School of Medicine, P.O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Family Medicine

#### Diagnosis & Management of the Acute Cardiac Patient

**For:** FP's. **Lecture,** Nov. 3-5, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$250. **Reg. limit:** 80. **Credit:** Category 1, 20 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Family Medicine

### Therapeutics

**For:** MD's. Lecture, Nov. 13-14, Madison, WI. **Sponsor:** U of WI-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** \$145. **Reg. limit:** none. **Credit:** Category 1, 12 hours; AOA, 12 hours; AAFP Prescribed, applied for. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Internal Medicine

### Cardiovascular Disease

**For:** MD's. Seminar, 8:00 a.m., Nov. 3, Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan. **Fee:** \$5. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312/578-2555.

## Internal Medicine

### Lake County Medical/Surgical Seminar

**For:** MD's. Seminar, Oct. 6, 8:00 a.m., Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan 60085. **Fee:** \$5. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312/578-2555.

## Malignant Disease

### Oncology Symposium

**For:** MD's. Symposium, Nov. 17, 1:00 p.m., Marion. **Sponsor:** SIU School of Medicine, P.O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Medicine

### Advances in Internal Medicine

**For:** Internists. Lecture, Nov. 15-19, Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Credit:** Category 1, 35 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## OB/GYN

### OB/GYN Seminar-at-Sea

**For:** MD's. Symposium/Cruise, Nov. 27-Dec. 7, Caribbean. **Sponsor:** SIU School of Medicine, P.O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 48 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Ophthalmology

### Basic and Clinical Review

**For:** MD's. Symposium, Nov. 26-30, Dearborn, MI. **Sponsor:** Wayne State University School of Medicine, CME, 4201 St. Antoine, 4H UHC, Detroit, MI 48201. **Fee:** \$450. **Reg. limit:** none. **Credit:** Category 1, 44 hours. **Contact:** Gerald Prieur, Jr. **Phone:** 313/577-1180.

## Pathology

### Liver and GI Clinico-Pathologic Conference

**For:** MD's. Lecture, Nov. 30, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Pharmacology

### Practical Pharmacology

**For:** MD's. Symposium, Nov. 9, 7:00 p.m., Effingham. **Sponsor:** SIU School of Medicine, P.O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 3 hours; AAFP Prescribed, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Primary Care

### Annual Thyroid Workshop

**For:** MD's. Workshop, Nov. 3, Detroit, MI. **Sponsor:** Wayne State University School of Medicine, CME, 4201 St. Antoine, 4H UHC, Detroit, MI 48201. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 6 hours. **Contact:** Gerald Prieur, Jr. **Phone:** 313/577-1180.

## Psychiatry

### Contemporary Topics in Psychiatry

**For:** Psychiatrists, Neurologists. Lecture, Nov. 8-12, Chicago. **Speaker:** Francois Alauf, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$375. **Reg. limit:** 85. **Credit:** Category 1, 42 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Psychiatry

### Office & Hospital Treatment of Chemical Dependence

**For:** Psychiatrists, Internists. Lecture, Nov. 4-6, Chicago. **Speaker:** Francois Alauf, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$250. **Reg. limit:** 85. **Credit:** Category 1, 20 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Respiratory Critical Care

### Respiratory Critical Care Symposium

**For:** MD's. Symposium/workshops, Nov. 4-6, Madison, WI. **Sponsor:** U of WI—Extension, CME, 465B WARF Bldg., 610 Walnut, Madison, WI 53706. **Fee:** \$225. **Reg. limit:** none. **Credit:** Category 1, 18 hours; AOA, 18 hours; AAFP Prescribed, applied for. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Rheumatology

### Purine Metabolism

**For:** MD's. Lecture, Nov. 8, 9:00 a.m., North Chicago. **Speaker:** B. Rothschild, MD. **Sponsor:** Dept. of Rheumatology, UHS/CMS, 3333 Green Bay Rd., North Chicago. **Fee:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Rheumatology

### Endorphins

**For:** MD's. Lecture, Nov. 22, 9:00 a.m., North Chicago. **Speaker:** Seymour Ehrenpreis, PhD. **Sponsor:** Dept. of Rheumatology, UHS/CMS, 3333 Green Bay Rd., North Chicago. **Fee:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Sports Medicine

### Athletic Injuries

**For:** MD's. Symposium, Nov. 3, 1:00 p.m., Alton. **Sponsor:** SIU School of Medicine, P.O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Surgery

### Flexible Fiberoptic Sigmoidoscopy

**For:** Surgeons. Lecture, Nov. 20, Chicago. **Speaker:** Herand Albarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$125. **Reg. limit:** 60. **Credit:** Category 1, 7 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

### Advanced Peripheral Vascular Surgery

**For:** Peripheral Vascular Surgeons. Lecture, Nov. 29-Dec. 3, Chicago. **Speaker:** D. Preston Flanigan, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Reg. limit:** 80. **Credit:** Category 1, 34 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

### Acute Injuries of the Hand, Primary & Definitive Care

**For:** Surgeons. Symposium, Nov. 18-20, Detroit, MI. **Sponsor:** Wayne State University School of Medicine, CME, 4201 St. Antoine, 4H UHC, Detroit, MI 48201. **Credit:** Category 1, 19 hours. **Contact:** Gerald Prieur, Jr. **Phone:** 313/577-1180.

## Surgery

### Fiberoptic Esophagogastric Endoscopy

**For:** Surgeons, Internists, Gastroenterologists. Lecture, Nov. 15-17, Chicago. **Speaker:** C. Thomas Bombace, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

### Burns

**For:** MD's. Symposium, Nov. 11, 1:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, P.O. Box 3926, CME, Springfield 62703. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Terminal Illness

### Hospice

**For:** MD's. Lecture, Nov. 5, 8:00 a.m., Chicago. **Speaker:** Sheldon Burchman, MD. **Sponsor:** Grant Hospital, CME, 550 W. Webster Ave., Chicago 60614. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Sharon Smith. **Phone:** 312/883-2112.

# DECEMBER

## Cardiology

### Ambulatory Electrocardiography

**For:** GP's, FP's, Internists. Seminar, Dec. 3-4, Hyatt Regency, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Dr. E., Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **Contact:** Doris Price. **Phone:** 800/525-8651 x 123.

## Cardiology

### Coronary Artery Disease Update

**For:** Primary Care Physicians. Lecture/workshops, Dec. 3-4, Madison, WI. **Sponsor:** U of WI-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1; AAFP Prescribed, applied for; AOA, applied for. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Internal Medicine

### Lake County Medical Surgical Seminar

**For:** MD's. Seminar, 8:00 a.m., Dec. 15, Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan 60085. **Reg. deadline:** 12/13. **Fee:** \$5. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312/578-2555.

## Neurology

### Neurology for the Non-Neurologist

**For:** Internists, FP's, Psychiatrists. Course, Dec. 8-10, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, CME, 600 S. Paulina, Chicago 60612. **Reg. deadline:** none. **Fee:** \$350. **Reg. limit:** none. **Credit:** Category 1, 20 hours. **Contact:** Barbara Trejo. **Phone:** 312/942-7095.

## Pathology

### Liver & GI Clinico-Pathologic Conference

**For:** MD's. Lecture, Dec. 27, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Rheumatology

### Fibrinolysis

**For:** MD's. Lecture, 9:00 a.m., Dec. 6, North Chicago. **Speaker:** Nicholas Joyce-Clarke, MD. **Sponsor:** Dept. of Rheumatology, UHS/CMS, 3333 Green Bay Rd., North Chicago. **Fee:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Rheumatology

### Cyclic Nucleotides

**For:** MD's. Lecture, 9:00 a.m., Dec. 20, North Chicago. **Speaker:** Ira Fenton, DO. **Sponsor:** Dept. of Rheumatology, UHS/CMS, 3333 Green Bay Rd., North Chicago. **Fee:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.



For geriatric patients,  
starting low is starting right...







# the Valium® 2-mg tablet (diazepam/Roche)

## The unique advantage of "mind and muscle" actions

Of all the benzodiazepines, only Valium (diazepam/Roche) provides two distinct and clinically valuable effects—antianxiety action and, when used adjunctively, relief of skeletal muscle spasm due to local pathology. These distinctive "mind" and "muscle" actions make Valium uniquely versatile.

As a calming agent, Valium 2 mg is a particularly appropriate choice for the excessively anxious elderly patient. The 2-mg dosage strength of Valium, daily or *b.i.d.*, is usually sufficient to relieve dysfunctional anxiety and its associated somatic symptoms promptly and reliably.

And, even at low dosages, adjunctive Valium can be helpful in managing the geriatric patient with skeletal muscle spasm due to local pathology (e.g., the "low back" patient or the one with muscle "strain").

The 2-mg tablet is scored, making it easier to initiate therapy with the smallest effective amount, in order to forestall oversedation or ataxia. For most elderly or debilitated patients, 2 to 2½ mg, once or twice daily, is the recommended starting dosage, to be gradually increased or decreased as needed and tolerated.

## Rapid absorption

Because of its rapid and complete absorption, Valium (diazepam/Roche) achieves peak blood levels in 60 to 90 minutes after a single dose. Patients, therefore, may experience some relief within hours after therapy begins. Absorption of Valium is not significantly affected by changes in the physiologic pH range in the GI tract. And Valium is well tolerated by most patients. Although drowsiness, ataxia and fatigue are sometimes encountered, they are rarely severe.

## Unmatched history of clinical effectiveness

Through the years, hundreds of reports have been published attesting to the clinical effectiveness of Valium (diazepam/Roche). A dependable and widely trusted psychotropic, Valium has fully established its ability to relieve symptoms of excessive anxiety in a variety of clinical situations—producing the distinctive antianxiety response that clinicians know, want and expect.

## Unmatched range of indications

In both office and hospital practice, only Valium (diazepam/Roche) does so much so well. One reason: Valium can claim not only clinically useful "mind and muscle" effects but anticonvulsant properties as well. The most versatile of the benzodiazepines, Valium is most widely known as a dependable anxiolytic, producing prompt relief of excessive anxiety, whether seen alone or associated with functional or organic disorders. In addition, adjunctive Valium is often an important asset in programs designed to relieve skeletal muscle spasm due to local pathology or to control certain seizure disorders.

Valium fits well into most therapeutic regimens because it is used with many primary medications, such as cardiac glycosides, diuretics, antacids, vasodilators and anticoagulants. The clearance of Valium and certain other benzodiazepines can be delayed by cimetidine administration, but the clinical significance of this is unclear. Patients should be cautioned against drinking alcohol, driving or operating machinery while taking Valium, as with all agents that act on the CNS. Periodic reassessment of the usefulness of continued therapy with Valium is recommended.

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Before prescribing, please see summary of product information on following page.

ROCHE



# Valium® (diazepam/Roche) (IV)

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anti-convulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**How Supplied:** For oral administration, Valium scored tablets—2 mg, white, 5 mg, yellow, 10 mg, blue—bottles of 100,\* and 500,\* Prescription Paks of 50, available in trays of 10.\* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

\*Supplied by Roche Products Inc., Manati, Puerto Rico 00701

†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110

## "I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

October 4	Christ Hospital & ACS	Oak Lawn
October 4	Alexian Bros. Med. Ctr.	Elk Grove Village
October 4	St. Francis Hosp. & ACS	Evanston
October 4	Sherman Hospital & ACS	Elgin
October 6	Lake Forest Hospital & ACS	Lake Forest
October 11	Hinsdale Sanitarium & ACS	Hinsdale
October 17	Victory Memorial Hosp. & ACS	Waukegan
October 18	Community Hospital	Geneva
October 18	Lutheran General Hospital	Park Ridge
October 19	Mercy Health Care Cntr. & ACS	Justice
October 21	ACS Training	Chicago
November 1	St. Theresa Area Trauma Satellite	Lake Villa
November 3	Hinsdale Sanitarium & ACS	Hinsdale
November 9	St. Francis Hospital & ACS	Blue Island
November 18	ACS Training	Chicago
December 6	Anchor & ACS	Chicago
December 6	Christ Hospital & ACS	Oak Lawn
December 7	Palatine Library & ACS	Palatine



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# Doctor's News

**RESOURCE DIRECTORY FOR DISABLED PHYSICIANS**—The St. Paul-Ramsey Medical Education and Research Foundation is compiling a resource directory for physicians with physical disability. The project is designed to form a voluntary group of physicians to provide information and referral services as well as support and advocacy to physicians who incur the same disability and need specific information. All physicians with physical disability of any kind are encouraged to contact Frank C. Zondlo, M.D., St. Paul-Ramsey Hospital Medical Education and Research Foundation, 640 Jackson Street, St. Paul, Minnesota 55101 or call (612) 221-3456.

**SHORT-DATED VACCINE DISTRIBUTION**—The Illinois Department of Public Health has adopted a policy to distribute short-dated vaccine for childhood preventable diseases. Although IDPH was forced to limit free distribution of the vaccines to public clinics due to reductions in federal and state funds, those vaccines which cannot be used in the clinics before expiration date will be distributed to other health care providers.

Stipulations and order of contact for the distribution are as follows: (1) Volume providers will be contacted by the Department of Public Aid if they are in the Medichex Program, can use short-dated vaccine and fill out usage data on the accountability form; (2) Large volume private physicians in highly populated counties without a health department will be contacted in descending order with the highest volume providers contacted first; (3) Large volume private physicians in highly populated counties with health departments will be contacted in descending order.

Vaccine usage data must be submitted by each provider on the designated state vaccine accountability form.

**NEW ANSWERING MACHINE**—Persons who telephone ISMS at (312) 782-1654 before 8:30 a.m. or after 4:45 p.m., will hear a recorded message. It is possible to leave a message so that calls can be returned during business hours. In order to reach physicians and staff after office hours parties may dial (312) 782-1655, which is a night line not linked to the automatic answering machine.

**NON-PROFIT GROUP TO FIGHT GENETIC DISORDER**—Friedreich's Ataxia Group in America is a non-profit organization designed to educate people about the genetic disorder Friedreich's Ataxia. The disorder usually begins in children between the ages of eight and fifteen, affecting the nervous system. Victims lose coordination, sensation and strength. Contributions made to F.A.G.A. are tax deductible and funds are applied to research and assistance in maintaining the organization. For more information write to Friedreich's Ataxia Group in America, Inc., P.O. Box 11116 Oakland, California 94611



**PHYSICIANS IN THE NEWS**—**John D. McKenzie, M.D.**, Park Ridge, was recently presented with the Alexander N. Ruggie Award for his accomplishments in exemplifying the philosophy of human ecology in the practice of medicine.

**Lawrence L. Hirsch, M.D.**, Chicago, has been appointed a member of the Medical Examining Committee of the Illinois Department of Registration and Education. Dr. Hirsch is professor and chairman of the Department of Family Medicine at the Chicago Medical School as well as a member of the ISMS Board of Trustees and a past president of the Chicago Medical Society. The seven-member committee makes recommendations to the director of the Department concerning candidates for licensure in the medical profession.

Three physicians were recently elected officers of the St. Francis Hospital (Blue Island) medical staff. They are **Glenn Gutzeit, M.D.**, Palos Heights, president; **Eugene Scherba, M.D.**, Flossmoor, president-elect; and **Joseph Musci, M.D.**, Orland Park, secretary-treasurer.

**Abel L. Robertson, Jr., M.D., Ph.D.**, was appointed head of the department of pathology at the University of Illinois College of Medicine in July. Dr. Robertson, professor of pathology at Case Western Reserve University School of Medicine in Cleveland, began his appointment on September 1, succeeding Samuel T. Nerenberg, M.D.

**Adriano Olivar, M.D.**, Chicago Heights, was recently elected president of the South Cook County Branch of the Chicago Medical Society. Other elected officers are: **Massoud Nourbash, M.D.**, secretary/treasurer and **John Schuetz, M.D.**, Chicago, council whip.

**Michael L. Nieder, M.D.**, Chicago, was elected as alternate delegate to the American Medical Association. **Virginia Sorum, M.D.** was recently named president of the Augustana Hospital and Health Care Center for a two-year term. **Jerry G. Simpson, M.D.**, has been named medical director of the West Suburban Hospital occupational health program.

**ANNUAL PATHOLOGY MEETING**—The United States-Canadian Division of the International Academy of Pathology will hold its annual meeting at the Atlanta Hilton, Atlanta, Georgia, from Monday February 28 through Friday March 3, 1983. The program will include scientific papers, twelve specialty conferences and 46 short courses. For more information contact Dr. Nathan Kaufman, secretary/treasurer, United States-Canadian Division of the International Academy of Pathology, 1003 Chafee Avenue, Augusta, Georgia, 30904. Telephone: (404) 724-2973.

**SYMPOSIUM OF ORIENTAL MEDICINE**—Chronic diseases will be the main subject of the Third International Symposium of Oriental Medicine, Thursday May 12th to Sunday May 15th 1983 in the Congress Hall of the Palais de Beaulieu, Lausanne, Switzerland. For more information contact Guido Fisch, M.D., Secretariat: 11, Chemin du Frene, CH-1004, Lausanne, Switzerland.

**ESTATE PLANNING INFORMATION**—Illinois State Medical Plans has a new estate planner. Stanley M. Pillman, J.D., CLU has replaced Jeffrey Stein as the person to contact for estate planning information. Stan may be reached at (312) 621-4938. Estate planning seminars will be offered shortly through the county societies.

If you need any information in the interim or if you would like to schedule an individual appointment, call Stan Pillman.

**LEGAL ASPECTS OF CLINICAL MEDICINE**—ISMS is a cooperating sponsor of a conference to be held November 11-12, 1982 at the Ambassador West Hotel, Chicago. The program, conducted by the American Society of Law and Medicine, will cover such issues as malpractice and hospital liability, allocating scarce health resources, the impaired health professional, patients' rights and decisional responsibilities and confidentiality.

Registration information is available by writing the American Society of Law and Medicine, 520 Commonwealth Ave., Boston, MA 02214 or by calling 617-262-4990.

# Your Professional Liability Insurance Checklist

## Do Other Carriers Measure Up?

### Use This List To Check Them Out

#### YOUR COMPANY

- ☐ Physician policyholders own the insurance company
- ☐ All profits returned to policyholders
- ☐ Program and policies established by physician owners
- ☐ Physician committees review all underwriting actions
- ☐ Active loss prevention education effort

#### YOUR COVERAGE

- ☐ Complete occurrence coverage – no “tail” problems
- ☐ Optional limits up to \$5 million
- ☐ Coverage for paramedical employees under your policy
- ☐ Coverage for temporary substitute (locum tenens)
- ☐ Satisfies hospital requirements—certificates of insurance provided

#### YOUR CLAIMS

- ☐ Vigorous defense of unjustified claims
- ☐ Physician committee review of claims defense
- ☐ Your participation in settle/defend decisions

#### YOUR PREMIUM

- ☐ Quarterly payment of premiums
- ☐ Part-time practice premium discounts
- ☐ Premium discounts for newly-in-practice physicians
- ☐ Suspension of coverage during prolonged absence
- ☐ Fully discounted to reflect investment income

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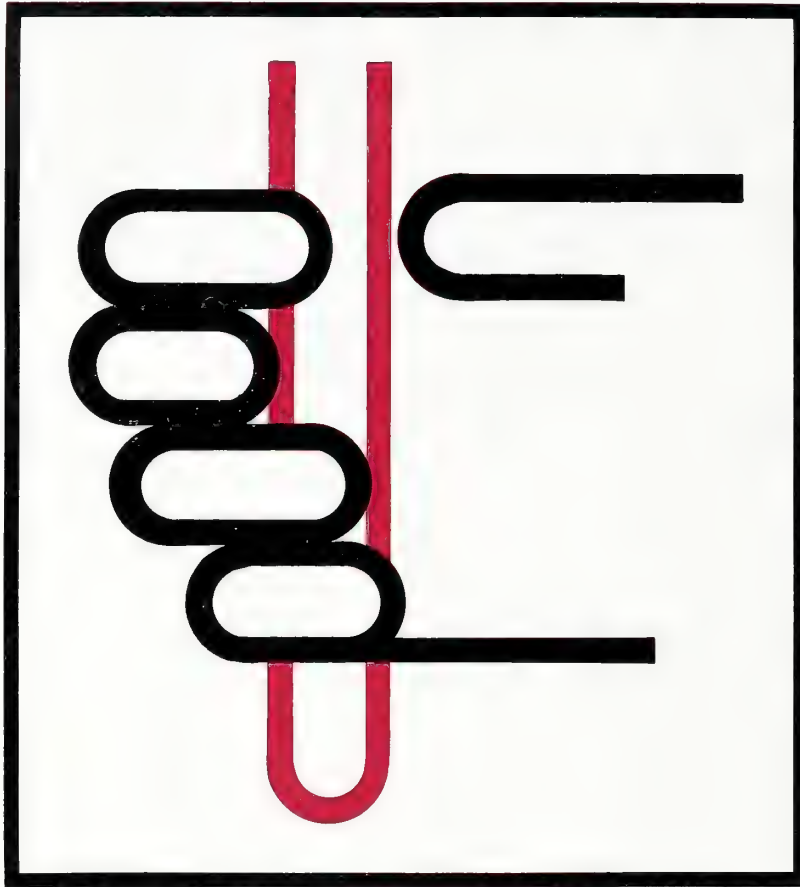
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# Destructive Osteolytic Bone Lesions In Chronic Granulocytic Leukemia

BY SIDNEY M. CRAIN, M.D., ABDUL M. CHOUDHURY, M.D., ZELMA  
MOLNAR, M.D., PH.D. AND VICTOR R. JABLOKOW, M.D./HINES

*Destructive myeloblastic osseous lesions are rare in chronic granulocytic leukemia. The clinical and pathologic features of two patients with chronic granulocytic leukemia who developed painful bone lesions are presented and the literature is reviewed. Biopsy of an osteolytic myeloblastic bone tumor indicated early metamorphosis without a previous chronic phase in one patient.*

Destructive osteolytic bone lesions due to extramedullary myeloblastic tumors are rarely found roentgenologically in adult patients with chronic granulocytic leukemia.<sup>1</sup> This is in contrast to acute granulocytic leukemia where such le-

sions may be found in 57-90% of cases.<sup>2</sup> The development of these extramedullary myeloblastic tumors in the bone,<sup>1</sup> meninges,<sup>3</sup> or lymph nodes<sup>4</sup> may be the earliest indication of metamorphosis. The occurrence of osseous lesions in chronic granulocytic leukemia is associated with rapid clinical deterioration due to progressive pancytopenia, myelofibrosis, or blastic transformation.<sup>1</sup> The clinical and pathologic features of two patients with chronic granulocytic leukemia who developed painful bone lesions are presented and the literature is reviewed.

## Case 1

A 58-year-old white male was admitted to Hines V.A. Hospital for control of adult onset diabetes mellitus. Physical examination on admission was unremarkable. Complete blood count revealed hemoglobin 12g/dl, hematocrit 37%, white blood cell count 9,200/mm<sup>3</sup> with 36% neutrophils, 5% bands, 5% eosinophils, 2% basophils, 50% lymphocytes, and 2% blasts. Platelet count was 850,000/mm<sup>3</sup>. An iliac crest bone marrow aspiration was performed to investigate the presence of peripheral blast cells. The bone marrow examination revealed a markedly increased number of megakaryocytes, and granulocytic hyperplasia with approximately 10% blast cells. Bone marrow karyotype examination demonstrated the presence of a Philadelphia chromosome with hypodiploidy (45XYPh<sup>1</sup>). Leukocyte alkaline phosphatase score was 130. A month after admission, the patient fell and injured his right leg. X-ray of the right femur revealed osteolytic erosion with a pathologic spiral fracture of the midfemoral shaft. (Figure 1) Bone scan demonstrated increased uptake over the site of the pathologic fracture. The patient was taken to surgery where he underwent pinning of the right femur with a Kirschner rod and methyl methacrylate cement. Open biopsy from

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**VICTOR R. JABLOKOW, M.D.**, is a board certified pathologic anatomist affiliated with Hines Veterans Administration Hospital. Dr. Jablokow is also a clinical professor of pathology, Loyola University School of Dentistry, and a former clinical associate professor in pathology, UI School of Medicine.

**ZELMA V. MOLNAR, M.D., Ph.D.**, is a board certified anatomic pathologist affiliated with Hines Veterans Administration Hospital and the Loyola University Stritch School of Medicine. A former recipient of the Hektoen Award for Medical Research, Dr. Molnar is chief of diagnostic electron microscopy at Hines.

**ABDUL M. CHOUDHURY, M.D.**, is a board certified internist affiliated with the Hines Veterans Administration Hospital, where he serves as assistant chief, hematology and oncology section. An assistant professor of medicine, Loyola University Stritch School of Medicine, Dr. Choudhury is also physician-in-chief at the Hines hematology/oncology outpatient clinic, and associate training director for their hematology/oncology fellowship program.



**SIDNEY M. CRAIN, M.D.**, is an oncologist engaged in research for the U.S. Public Health Service. At this writing, Dr. Crain was senior resident in the department of internal medicine at Hines Veterans Administration Hospital. He is presently engaged as a clinical associate for the Baltimore Cancer Research Program on a National Cancer Institute oncology research fellowship.







**Figure 1**

**X-ray of right femur from case one demonstrating osteolytic erosion with pathologic spiral fracture of the mid-femoral shaft.**

the fracture site revealed myeloblastic cells consistent with granulocytic sarcoma. The patient was then treated with 3000rads to the right femur with symptomatic improvement and subsequent X-ray evidence of healing.

A bone survey in September 1974 disclosed osteolytic involvement of the right humerus and both femurs. Radiation therapy was given to the involved sites. He developed a pathologic fracture of the 6th left rib. Blood count revealed hemoglobin 9.4 g/dl, white blood cell count 9,400/mm<sup>3</sup> with 31% neutrophils, 16% bands, 26% lymphocytes, 9% monocytes, 3% basophils, 6% myelocytes, 7% metamyelocytes, and 2% blasts. Platelet count was 900,000/mm<sup>3</sup>. The patient was begun on thioguanine.

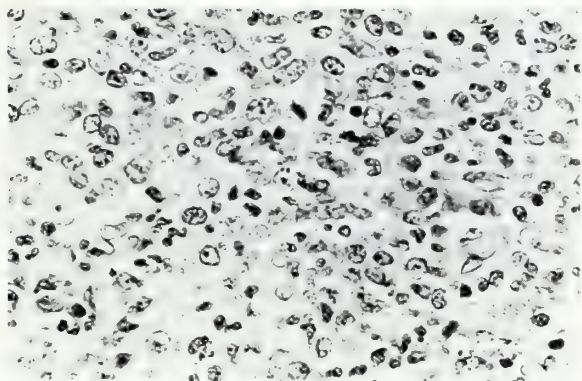
Thirteen months after first admission the patient developed abdominal and low back pain followed by difficulty in micturition and sudden paraplegia localized neurologically to the T3-4 level. X-rays revealed osteolytic lesions of the

3rd through 8th thoracic vertebrae. The patient was treated with 2400rads to his lumbar and thoracic spine. There was no evidence of organomegaly. Blood count revealed hemoglobin 10.2 g/dl, hematocrit 31%, white blood cell count 1,300/mm<sup>3</sup> with 3% neutrophils, 7% bands, 53% lymphocytes, 5% eosinophils, and 3% blasts. Chemotherapy was withheld due to leukopenia.

The patient experienced recurrent symptomatic osteolytic bone lesions of the right hip, pubis, sacrum, left knee, and frontal bone of the skull. These lesions were treated with local radiotherapy. Blood count during this period revealed hemoglobin 8 g/dl, hematocrit 25%, white blood cell count 2,000 with 25% neutrophils, 14% bands, 18% lymphocytes, 9% monocytes, 4% myelocytes, 9% metamyelocytes, and 20% blasts. Bone marrow aspirate examination demonstrated increase in blasts up to 40%. Megakaryocytes were adequate in number with many atypical forms. The patient was felt to be in blast crisis and no specific antileukemic chemotherapy was administered. He continued to deteriorate with symptomatic bone pain. He lapsed into coma and expired eighteen months after that admission. Autopsy revealed multiple areas of myeloblastic tumors (granulocytic sarcomas) involving the vertebrae, pelvis, both femurs, hilar and periaortic lymph nodes, liver, spleen, and the spinal cord epidural space from T5 to the cauda equina. The bone marrow was diffusely replaced with blast cells.

## **Case 2**

A 45-year-old white male was diagnosed with Ph<sup>1</sup> positive chronic granulocytic leukemia. Treatment was initiated with busulfan with prompt disappearance of splenomegaly and the return of well being. Eighteen months later he presented complaining of progressively increasing pain of his left thigh for the past two months. Pertinent physical findings were a liver span of 15cm, no lymphadenopathy or splenomegaly. Tenderness to palpation was present over the left greater trochanter. Blood count revealed hemoglobin 17g/dl, hematocrit 50%, white blood cell count 78,700 with 51% neutrophils, 20% bands, 15% lymphocytes, 6% myelocytes, 4% metamyelocytes, 1% blasts. Platelet count was 150,000/mm<sup>3</sup>. Serum calcium and alkaline phosphatase were normal. X-ray of the left femur was negative, however bone scan revealed increased uptake over the proximal shaft of the left femur. The lesion was considered to be a probable myeloblastic tumor, however a biopsy could not be obtained. The lesion was treated with local radiotherapy with symptomatic relief.



**Figure 2**

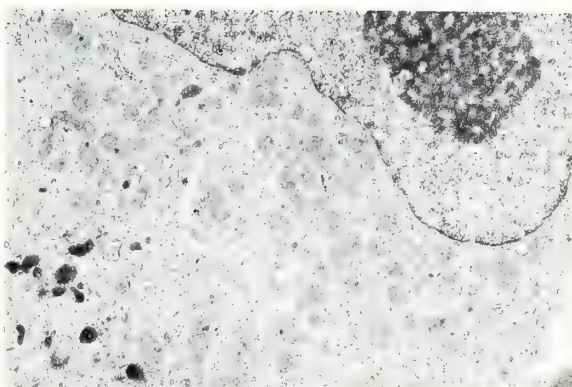
Hematoxylin-eosin stained tissue from case one demonstrating diffuse infiltration by undifferentiated neoplastic cells with large vesicular nuclei and small amounts of eosinophilic cytoplasm.

At 29 months after first visit, he was admitted to another hospital with fever, weight loss, lymphadenopathy, and massive splenomegaly. Blood count revealed hemoglobin 10.5g/dl, hematocrit 32%, white blood cell count 118,000 with 22% neutrophils, 14% bands, 7% monocytes, 1% myelocytes, 3% metamyelocytes, 40% blasts, and 20 nucleated RBCs. Platelet count was 20,000. The patient was considered to be in acute blastic transformation and was treated with hydroxyurea. On transfer to our facility bone marrow aspiration was unsuccessful due to a dry tap. Iliac crest bone marrow biopsy demonstrated diffuse replacement of the marrow with blast cells. Induction chemotherapy with adriamycin, cytosine arabinoside, vincristine, and prednisone was attempted without achieving remission.

Two months later he experienced an upper gastrointestinal hemorrhage and expired. At autopsy localized myeloblastic tumor was found in the proximal left femur in addition to marrow replacement. Multiple organ system involvement with blast cells was also noted.

## Pathology

Hematoxylin-eosin stained tissue sections and touch preparations, obtained by open biopsy from the site of pathologic fracture in case one and from the left proximal femur at autopsy in case two, revealed diffuse infiltration by undifferentiated neoplastic cells with large vesicular nuclei and small amounts of eosinophilic cytoplasm. (Figure 2)



**Figure 3**

High power electron micrograph of a representative cell from case two demonstrating finely dispersed nuclear chromatin and clusters of specific granules in the cytoplasm.

Electron microscopy of tissue from case two demonstrated a mononucleated population of cells with finely dispersed nuclear chromatin and 1-2 nucleoli attached to the nuclear membrane. The cytoplasm contained many polysomes, rough endoplasmic reticulum of variable length and focal clusters of membrane limited electron dense specific granules. (Figure 3)

## Discussion

The natural history of chronic granulocytic leukemia (CGL) is characterized by an initial chronic phase in which hyperplasia of mature myeloid cells in the bone marrow and peripheral blood occurs. During the chronic phase, the signs and symptoms are relatively uniform, response to therapy the rule, and the patient remains well unless the adverse effects of therapy or intercurrent unrelated illness complicate the clinical course.<sup>5</sup> The initial chronic phase of CGL is followed in the majority of patients by a phase of altered biologic behavior, whose variable clinical and hematologic manifestations have been termed "metamorphosis."<sup>6</sup> Three subgroups of the metamorphic phase have been delineated by Spiers: blast crisis, acute transformation, and the mixed subgroup.<sup>7</sup> The blast crisis is defined as the sudden appearance of large numbers of blast cells (30-90%) in the peripheral blood. During acute transformation, anemia, neutropenia and thrombocytopenia ensue with an increase in the number of myeloblasts and a decrease in the percentage of myelocytes in the bone marrow and peripheral blood. In the mixed subgroup of metamorphosis, an indolent smoldering course lasting



<b>Author Reference</b>	<b>Sex Age</b>	<b>At Onset of Lesion Duration of CGL (mo.)</b>	<b>Clinical Status</b>	<b>Ph</b>	<b>Location of Lesion</b>	<b>Histology</b>	<b>Time Interval From Lesion to Blast Crisis</b>	<b>Death</b>
Meyer <sup>27</sup>	52F	36	not stated	*	femur	Myeloblasts	not stated	2
Nesbitt <sup>28</sup>	42M	36	chronic phase	*	tibia	myelocytes	remained in chronic phase	1
Clements <sup>4</sup>	47F	22	peripheral remission	+	femur L2-3	myelocytes	remained in chronic phase	14
Knospe <sup>29</sup>	63M	26	blast crisis	+	skull pelvis	myeloblast	0	7
Chabner <sup>1</sup>	32F	22	peripheral remission	+	femur	myeloblasts	4	6
	41F	33	blast crisis	+	humerus	myeloblasts	0	3
	47M	23	chronic phase	+	ribs pelvis vertebrae	myeloblasts	remained in chronic phase	7
Muss <sup>13</sup>	36M	90	not stated	+	T3	myeloblasts	not stated	not stated
Campbell <sup>9</sup>	50F	UK	chronic	+	femur	myeloblasts	not stated	not stated
Spengler <sup>30</sup>	43M	17	blast	+	femur	myeloblasts	0	3
Joyner <sup>20</sup>	19F	8	blast crisis	+	femur	myeloblasts	0	1
Cavalli <sup>31</sup>	38F	2	chronic phase	UK	femur	myeloblasts	4	7
Rizzo <sup>22</sup>	49F	13	chronic phase	+	pelvis femur humerus skull	myeloblasts	5	6
	33F	14	chronic phase	+	femur pelvis	myeloblasts	4	6
Deliliers <sup>23</sup>	51M	42	peripheral remission	+	pelvis femur	myeloblasts	9	9.5
Longo <sup>11</sup>	45F	UK	aleukemic	+	femur	myeloblasts	—	1.5
Krug <sup>15</sup>	57M	15	chronic	UK	pelvis	myelocytes	not stated	5
* Predated discovery of Philadelphia chromosome								
UK Unknown								

from six months to two years occurs. The large number of immature cells found in the blast crisis and acute transformation are lacking. The metamorphosis of case one is best described as being of the mixed subgroup and case two of the acute transformation subgroup.

The presentation and clinical course of case one is of particular interest. Peripheral blood examination revealed only mild anemia, thrombocytosis, and rare blasts. Bone marrow examination demonstrated a hypercellular marrow, megakaryocytic hyperplasia, and 10% myeloblasts. Bone marrow karyotyping revealed the Philadelphia chromosome and hypodiploid karyotype. These findings were consistent with an early metamorphosis of CGL without a prodromal chronic phase. Within one month the patient suffered a pathologic fracture of the right femur

which proved on biopsy to be due to an extra-medullary myeloblastic tumor. CGL may present in blast crisis simulating acute leukemia without a documented previous chronic phase.<sup>8-10</sup> However, review of the literature reveals only one previously reported case in which a patient presented initially with an osteolytic bone lesion without the prodromal chronic phase of CGL.<sup>11</sup> The patient demonstrated a Ph<sup>1</sup> positive myeloproliferative syndrome with an inapparent chronic phase that progressed to myelofibrosis of the marrow and finally to blast transformation.

The Philadelphia chromosome is the only consistent chromosomal abnormality found in neoplastic disease and is found in 90% of all CGL patients. Its presence in acute myelocytic leukemia remains controversial and it is generally regarded as specific for CGL.<sup>12</sup>

It is noteworthy that case one developed acute spinal cord compression, producing sudden paraplegia with urinary retention. Muss and Moloney reported seven cases of CGL who were in clinical remission when myeloblastic tumors were discovered.<sup>13</sup> Acute cord compression developed in five of these patients and laminectomy followed by local radiotherapy produced objective improvement in three. Unfortunately, neurologic function was not restored in our patient by radiotherapy to the thoracic spine.

### Review of Literature

Table one summarizes the pertinent clinical data of previously reported cases of patients with CGL who developed osteolytic bone lesions. Myeloblastic tumors may occur during metamorphosis and frequently present as lymphadenopathy, subcutaneous tumors or, rarely, osteolytic bone lesions. Extramedullary metamorphosis is suspected when such lesions are found in the presence of blood and bone marrow findings which show only CGL in its chronic phase. In paraffin embedded tissue sections stained with hematoxylin and eosin, the primitive granulocytic cells are difficult to distinguish from malignant reticulum cells.<sup>14-16</sup> Earlier literature contains cases of CGL in whom biopsy was interpreted as malignant lymphoma.<sup>17-19</sup> For this reason, those cases in whom biopsy was interpreted as malignant lymphoma,<sup>17-19</sup> reticulum cell sarcoma<sup>18</sup> or in whom biopsy was not obtained,<sup>20,1,21,22,15,23-25</sup> were omitted from Table I.

Review of the literature yielded 17 previously reported cases of CGL with osteolytic bone lesions due to extramedullary metamorphosis. The mean duration of CGL at the onset of bone lesions was 26 months. Seven cases were in the chronic phase, five in blastemic phase, three in peripheral remission and one case was aleukemic at the onset of the symptomatic bone lesions. The bone lesions were all osteolytic in nature and occurred predominately in the femur and pelvis. As the disease progresses, multiple bone involvement occurs, resembling multiple myeloma. The occurrence of such lesions in CGL appears to signify a poor prognosis. The average time interval from the appearance of leukemic bone lesions to death was 4.7 months with a range of 1-14 months.

Analysis of the clinical course of our two cases of CGL yielded similar results. The mean duration of CGL at the onset of symptomatic bone lesions in our two cases was 2 and 18 months respectively. Case 2 was unique in that bone scan and not X-ray revealed early involvement of the left femur.

The mechanism by which myeloblastic lesions cause osteolysis remains speculative. Human leukocytes have been shown to secrete osteoclast activating factor (OAF), which in the case of multiple myeloma produce osteolytic bone destruction.<sup>26</sup> Whether the same mechanism is operative in the rare patient with CGL is unknown.

Local radiotherapy to the affected bone lesions was effective in producing symptomatic relief in both of our patients, however it had little effect on the already disseminated disease. It is possible that aggressive local radiotherapy to the site of isolated osseous extramedullary metamorphosis, with adjuvant chemotherapy effective in acute leukemia, may prevent blast dissemination.<sup>27</sup>

### Acknowledgement

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### References

A complete list of references for "Destructive Osteolytic Bone Lesions in Chronic Granulocytic Leukemia," may be obtained by writing the Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago IL 60603.

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## Medical Antiques

*(Continued from page 203)*

part of my collection is currently on display as a modest museum of medical history in the lobby of our hospital. I have encouraged colleagues to lend us what medical antiques they may have, and the resulting museum has proved an attractive addition to our lobby, engaging the attention and interest of visitors and staff alike. A few of my larger pieces have been used for storage of smaller items, thus serving both a functional and decorative purpose in my home.

Many medical antiques embody a quality of material and standard of workmanship seldom seen today. The handicraft apparent in the manufacture of these pieces demonstrates how closely a craft can resemble an art. To be involved is to become aware, and those who examine the artifacts of the past establish a unique communication with its artisans. When you hold an early medical implement, you know how it felt to the one who used it. In that instant you are engaged in an intimate contact with your heritage, and you are as close to your professional forebear as you can be. Collecting medical antiques has many joys, but none is greater than the understanding it brings of our history and the continuity of effort which brought us to where we stand today. ◀



# IMPAC

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“The morals and intelligence of a democratic people would be in as much danger as its commerce and industry if ever a government wholly usurped the place of private associations.”

Alexis de Tocqueville

# Seminars in Immunopathology and Oncology

Richard J. Ablin, Ph.D., Contributing Editor

## Clinical Applications of HLA Testing

BY WILLIAM E. BRAUN, M.D./CLEVELAND

Leukocyte antibodies were first investigated in 1926 by Doan because of their suspected involvement in transfusion reactions.<sup>1</sup> But it was not until 1952 when Dausset described his studies of leukocyte agglutinating antibodies, then suspected of being involved with chronic agranulocytosis, that a sustained series of investigations of leukocyte antigens began.<sup>2</sup> However, the initial area of applicability, namely, transfusion reactions and pancytopenia, and the technique of detecting these antibodies, namely, agglutination, have been set aside from the mainstream of leukocyte antigen and antibody studies. Currently the primary areas of interest for the human leukocyte antigens (HLA) are in organ transplantation, disease susceptibility, and paternity testing. Moreover, the primary technique being used to identify these antigens is the micro-lymphocytotoxicity test. This advanced state of development of HLA testing was possible because of the pioneering studies of such workers as Amos, Brittingham, Chaplin, Dausset, Gorer, Payne, Terasaki, and van Rood. Some of these workers and many others from around the world since 1964 have conducted eight International HLA Workshops which have created a forum for presenting data describing the genetic control of the HLA system, the similar composition of the human and animal major histocompatibility complexes (MHCs), an increasingly large number of antigenic specificities (Table 1),<sup>3</sup> the biochemistry of HLA antigens, and their role in gene mapping, anthropologic studies, immune regulation, disease susceptibility, and organ transplantation. Work in these areas was highlighted by the awarding of the Nobel Prize for Medicine in 1980 to three

preeminent investigators: Baruj Benacerraf, Jean Dausset, and George Snell.

Numerous reviews and an extensive literature are available concerning many of the abbreviated facts that will be presented here as a working basis for understanding the HLA system.<sup>4-7</sup> The genetic loci which control the HLA antigen system are located on the short arm of the sixth chromosome in a region known as the major histocompatibility complex (MHC). There are believed to be 5 loci: A, B, C, D, and DR which have as their gene products the series of antigens named according to the locus plus a numeral indicating the specificity of the antigen. An example would be A2, often more formally designated for the species, too, as HLA-A2. The A, B, C, and DR locus antigens are serologically defined. The D locus antigens are identified by homozygous typing cells (HTC) using mixed lymphocyte culture reactions. The A, B, and C series of antigens (Class 1 antigens) are present on both T and B lymphocytes. In contrast, the D and DR series of antigens (Class 2 antigens) are expressed predominantly on B lymphocytes.

The biochemistry of the A and B series of antigens indicate that they are composed of two polypeptide chains, the heavier one of which possesses the HLA allospecificity and has a molecular weight of approximately 44,000 daltons. Non-covalently bound to it is an 11,700 molecular weight polypeptide structure that is identical to  $\beta_2$ -microglobulin. Biochemical studies of the DR molecules indicate that they are composed of two nearly identically sized polypeptide chains, one approximately 33,000 daltons (the  $\alpha$  chain) and the other a 28,000 dalton chain (the  $\beta$  chain). The polymorphism of the DR antigen appears to reside in the  $\beta$  chain.

The A and B series of antigens are present in soluble form in serum, saliva, and urine, as well as on the surface of reticulocytes and virtually all nucleated cells in man. They are detectable only very weakly if at all on mature erythrocytes. The D and DR antigens are expressed primarily on B lymphocytes, monocytes, macrophages, endothelial cells, bone marrow precursor cells, some

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**WILLIAM E. BRAUN, M.D.**, is chief of the Medical Renal Transplantation Service and director of the Histocompatibility Laboratory, for the Cleveland Clinic Foundation. A staff physician in the department of hypertension and nephrology and division of laboratory medicine at the Cleveland Clinic, he is board certified in both internal medicine and nephrology.



**Table 1**  
**Listing of Recognized HLA Specificities**

HLA-A	HLA-B	HLA-C	HLA-D	HLA-DR
HLA-A1	HLA-B5	HLA-Cw1	HLA-Dw1	HLA-DR1
HLA-A2	HLA-B7	HLA-Cw2	HLA-Dw2	HLA-DR2
HLA-A3	HLA-B8	HLA-Cw3	HLA-Dw3	HLA-DR3
HLA-A9	HLA-B12	HLA-Cw4	HLA-Dw4	HLA-DR4
HLA-A10	HLA-B13	HLA-Cw5	HLA-Dw5	HLA-DR5
HLA-A11	HLA-B14	HLA-Cw6	HLA-Dw6	HLA-DRw6
HLA-Aw19	HLA-B15	HLA-Cw7	HLA-Dw7	HLA-DR7
HLA-Aw23 (9)	HLA-Bw16	HLA-Cw8	HLA-Dw8	HLA-DRw8
HLA-Aw24 (9)	HLA-B17		HLA-Dw9	HLA-DRw9
HLA-A25 (10)	HLA-B18		HLA-Dw10	HLA-DRw10
HLA-A26 (10)	HLA-Bw21		HLA-Dw11	
HLA-A28	HLA-Bw22		HLA-Dw12	
HLA-A29	HLA-B27			
HLA-Aw30	HLA-Bw35			
HLA-Aw31	HLA-B37			
HLA-A29	HLA-Bw38 (w16)			
HLA-Aw32	HLA-Bw39 (w16)			
HLA-Aw33	HLA-B40			
HLA-Aw34	HLA-Bw41			
HLA-Aw36	HLA-Bw42			
HLA-Aw43	HLA-Bw44 (12)			
	HLA-Bw45 (12)			
	HLA-Bw46			
	HLA-Bw47			
	HLA-Bw48			
	HLA-Bw49 (w21)			
	HLA-Bw50 (w21)			
	HLA-Bw51 (5)			
	HLA-Bw52 (5)			
	HLA-Bw53			
	HLA-Bw54 (w22)			
	HLA-Bw55 (w22)			
	HLA-Bw56 (w22)			
	HLA-Bw57 (17)			
	HLA-Bw58 (17)			
	HLA-Bw59			
	HLA-Bw60 (40)			
	HLA-Bw61 (40)			
	HLA-Bw62 (15)			
	HLA-Bw63 (15)			
	HLA-Bw4			
	HLA-Bw6			

**Footnote to Table 1**

In parentheses are the numbers of the broad specificities which include the narrow specificity or split which precedes them.

Broad Specificity	Narrow Specificity Or Split
HLA-A9	Aw23, Aw24
HLA-A10	A25, A26
HLA-B5	Bw51, Bw52
HLA-B12	Bw44, Bw45
HLA-B15	Bw62, Bw63
HLA-Bw16	Bw38, Bw39
HLA-B17	Bw57, Bw58
HLA-Bw21	Bw49, Bw50
HLA-Bw22	Bw54, Bw55, Bw56
HLA-B40	Bw60, Bw61

tumors, Langerhans cells of the epidermis, sperm, and activated T cells.

The HLA antibodies which are used to identify the presence of these antigens are produced primarily by parous females, organ transplant recipients, and now by monoclonal techniques. Although HLA antibodies may be formed after blood transfusions and in the past have been produced by intentional immunizations with lymphocytes, these sources are rarely used.

HLA antigens are inherited in a codominant fashion. The contribution of HLA antigens of one parent to an offspring is designated a haplotype, which currently would include one antigen

from each of the five HLA antigen series. Consequently, a person with one haplotype inherited from each parent would have a genotype composed of 10 antigens, two of each series. Because of the difficulty in typing for the D locus by HTCs, in clinical use one will generally be working with A, B, C and DR antigens. Since the DR antigens are very good representations of at least one of the D region loci, it has become more practical to perform B lymphocyte typing by this method.

A typical family in which each parent has two different haplotypes and a full representation of the A, B, C, and DR series of antigens would have an inheritance pattern as shown in Figure

Figure 1  
HLA FAMILY STUDY

Father	DR	B	C	A	(or)		Mother	DR	B	C	A	(or)	
	2	7	2	3		a		3	8	3	1		c
	4	44	5	23		b		1	35	4	11		d
a			a			b	b			a			
c			d			c	d			c			
Child 1			Child 2			Child 3	Child 4				Child 5		

1. Among children there is a 25% chance of a two-haplotype identical pair of offspring, a 25% chance of a zero haplotype matched pair, and a 50% chance of a one haplotype matched pair. If the unusual occurrence took place in which parents shared a haplotype, then there would be the possibility of HLA identical parent-child combinations as well. The chances of a recombination event occurring between two of these linked HLA loci on the sixth chromosome is less than 1% and will vary according to the distance between the two loci involved.

Certain of the HLA antigens tend to occur more frequently in the company of one another than would be expected on the basis of their individual frequencies in the population. This affinity for antigen pairing is called "linkage disequilibrium" and is exemplified best by the antigens A1 and B8 that occur in the caucasian population together more frequently (6.2%) than they should based on their individual frequencies (0.7%). In addition to these considerations about HLA antigens there is also extensive information concerning cross reactivity between certain of these antigens as well as the racial differences in the frequencies of these antigens.<sup>8</sup>

The balance of this paper will consider current applications of the HLA system.

## Organ Transplantation

When a renal transplant is to be performed, if one can identify a serologically HLA identical, MLC non-stimulatory sibling or parent within that family, the chance for a successful allograft is about 90% as judged approximately two years post-transplantation. If one finds only a serologically HLA-mismatched donor in the family, then MLC stimulation or non-stimulation becomes an important discriminating consideration. If there is only a very low level of MLC stimulation between the serologically mismatched individuals, then the chance for a successful allograft

without any additional pre-transplant preparation is in excess of 80%.<sup>9,10</sup> However, if there is MLC stimulation, the chance of a transplant succeeding is often less than 50% and perhaps as low as 30%, so that this group has been treated with a pre-transplant donor specific blood transfusion protocol.<sup>11</sup> This protocol, originally developed by the transplantation team at the University of California at San Francisco, involves giving three 200cc transfusions of fresh donor blood at two week intervals prior to the renal allografting. With this protocol approximately 25-33% of the patients transfused will make a donor reactive antibody that precludes performance of that transplant. However, the remaining majority of patients who go on to receive the renal transplant from the same donor who gave the blood transfusions have had a remarkably high allograft success rate of at least 90% one year after transplantation. This represents nearly a doubling of the success rate that would have been encountered in these high MLC stimulatory pairs if the donor-specific transfusions had not been given. In such a procedure, it is essential that the crossmatching techniques be very sensitive and carefully timed in order to prevent an hyperacute rejection from happening because of donor reactive antibody. To date, those patients who become sensitized to their family donor after transfusion have been as able as others to be transplanted with cadaver organs.

In the area of cadaver organ transplantation, blood transfusions from random donors have also had a dramatic impact on the success rates. In some groups the presence of random transfusions has made as much as a 20-30% difference in the one year allograft survival of cadaver kidneys.<sup>12</sup> Moreover, in some series there has also been the indication that this is a dose-related effect that is detectable with just a single transfusion and, in the most recent information from Terasaki's laboratory, appears to rise sharply with three transfusions and to peak in its effectiveness at approximately 14 transfusions. The mechanism



for the beneficial transfusion effect is unknown but is being investigated intensively in the areas of suppressor cell induction and anti-idiotypic antibodies.

Superimposed on the transfusion effect is an additional benefit derived from matching the DR antigens on B lymphocytes. The effect of DR matching does not seem to be replaceable by the transfusion effect, and one seems to complement the other. In fact, it is suggested that the transfusion effect is predominantly expressed within the first year after transplantation while the HLA matching effect assumes a gradually increasing role beyond the first year. This type of long-term matching effect was first described by Dausset who noted that the initial recipients whom he had studied in 1974 showed nearly twice the graft survival at eight years when they had two or more of the A and B series of antigens matched as they did if they had only 0 or 1 A and B antigen matched.<sup>13,14</sup> It should be noted that HLA-A and B matching for cadaver renal transplants still remains the most commonly used form of tissue typing and also contributes a small but statistically significant early benefit to the recipient.

But DR matching for cadaver transplantation is assuming a steadily larger role. From recent studies it would appear that if one can match for both DR antigens the chances of a successful allograft from a cadaver donor are in excess of 90%.<sup>15-17</sup> If one can match for only one DR antigen the success rates are in the range of 50-65% with considerable overlap by the 0 DR antigen matched group. There is early evidence to suggest that if one can match for either a single DR antigen or at least two of the A and B series of antigens the success rates are in excess of 70%.<sup>18</sup> In contrast, if one cannot match for any DR antigen or only 0 or 1 of the A and B series antigens, the success rates are less than 40%.

A word should be said about the detection of HLA presensitization in potential renal allograft recipients using sensitive crossmatching techniques. The usual crossmatching procedure in the past has involved testing against donor peripheral blood, lymph node or splenic lymphocytes the recipient's most recent serum specimen and other appropriately selected serum specimens which have previously been found on screening to have HLA reactivity. These sources of cells contain a mixed population of T and B cells. In order to avoid uncertainty in the specificity of the antibody with a mixed lymphocyte population, numerous laboratories are now separating T and B cells and performing separate crossmatches with each subpopulation. A positive crossmatch against donor T cells with the current recipient serum is still

considered a contraindication to proceeding with the transplant. A more difficult question arises with positive reactions to donor B cells. Although some reports have indicated that positive B cell crossmatches can be ignored and the transplant safely performed,<sup>19,20</sup> there are a number of reports which clearly have demonstrated that certain types of positive B cell crossmatches are associated either with hyperacute or accelerated allograft rejections.<sup>21-25</sup> At the present time the three categories of potentially dangerous B cell crossmatches appear to be those which have a DR specificity to them (and this would require information about these antibodies from previous screening results against B lymphocyte panels), B cell antibodies which are present in high titer (generally in the range of 1:32 or 1:64), and possibly warm B cell antibodies (although there is a substantial amount of uncertainty about the influence of temperature-defined antibodies on immediate rejections). However, it is clear that the almost universal willingness to ignore positive B cell crossmatches is changing, and certain types of B cell crossmatches are now being considered as serious hazards to successful transplantation.

### Disease Susceptibility

The work of Frank Lilly in the mid-1960's which showed that in the mouse, resistance to the oncogenic properties of the Gross leukemia virus (Rgv) was genetically controlled by a locus in the major histocompatibility complex (MHC)<sup>26</sup> set the stage for a tremendous outpouring of studies over the past 15 years involving a search in man for disease associations and linkage with HLA antigens and HLA loci, respectively.<sup>27-30</sup> Association and linkage are different phenomena, the former being the nonrandom occurrence of two genetically separate traits in a population, whereas the latter is the occurrence of two loci on a single chromosome sufficiently close together that less than independent assortment occurs. From a practical point of view association studies are done in unrelated populations and linkage studies are done in families. Association does not depend on linkage, but because of linkage disequilibrium there may be at times linkage existing with a predominant HLA antigen or haplotype. Some examples of these phenomena are the association of B27 with ankylosing spondylitis, the linkage of HLA with the 21-hydroxylase type of congenital adrenal hyperplasia, and linkage between HLA and idiopathic hemochromatosis with the additional linkage disequilibrium for HLA-A3.

The causation of disease when linkage is involved seems clear enough. The specific diseases

which have been reported to be linked to the HLA loci are idiopathic hemochromatosis, congenital adrenal hyperplasia of the 21-hydroxylase deficiency type, hypertrophic cardiomyopathy, spinocerebellar ataxia, and Paget's disease of bone. Complement components C2, C4, and Bf are also linked to HLA. There has been suggestive evidence that familial rheumatoid arthritis, diabetes mellitus, multiple sclerosis, and the familial cancer syndrome may also be controlled by genetic loci close to those of HLA.

The more difficult problem has been in understanding why, when association is involved, an HLA antigen predisposes to a particular disease. One principal hypothesis has been to consider the HLA antigens as molecular mimics of pathogenic agents, so that the host would not be able to distinguish from its own HLA antigens the offending pathogen and consequently be unable to eliminate it. Some evidence has been presented to support this mechanism being involved in ankylosing spondylitis because of cross reactivity between certain *Klebsiella* strains and the B27 antigen. A second major hypothesis centers on HLA antigens acting as receptor sites for a pathogenic organism or chemical. Although there is MHC restriction to the action of cytotoxic cells against certain viruses, there is no specific proof that the HLA antigens are precisely a receptor site for viruses. There has been some evidence, however, to suggest that HLA-B8 may be a receptor for alpha gliadin in the development of gluten sensitive enteropathy.

In contrast to the relatively small number of diseases that have been linked to the HLA loci, there are a large number of diseases which have had significant associations found with certain HLA antigens. Although an antigen association may have some statistical significance, the clinical usefulness of such an association may be extremely poor, usually because of the low prevalence of the disease in question as well as the relatively high frequency of the antigen in the normal population.

In general the clinical usefulness of HLA antigen associations may be viewed in two ways. The first way estimates a person's relative risk (RR) for a certain disease that the presence of a particular HLA antigen contributes. This RR can be calculated simply as the ratio of patients having the antigen to patients lacking the antigen, and of controls having the antigen to controls not having the antigen. The product of the number of patients having the antigen and the number of controls lacking the antigen divided by the product of the patients lacking the antigen and the controls having the antigen yields the RR.

The highest relative risk calculated for any disease is for B27 and ankylosing spondylitis (AS). In many series the RR for AS in caucasians with B27 is in excess of 100. When one examines other races, the same antigen may have a substantially lower RR for the same disease. For example, in American blacks the relative risk for AS with B27 is reduced to approximately 25, and only about 50% of American blacks with AS have B27.

Ankylosing spondylitis is also a good example of the second approach to the clinical usefulness of HLA testing which evaluates the results of the test in conjunction with the prior probability that the disease is present based on quantitated clinical diagnostic criteria.<sup>27,31,32</sup> It has its greatest usefulness in a situation in which the diagnosis is far from clear and in which, perhaps, only a 50% prior probability of the disease exists. This 50% probability can be increased to more than a 90% probability in an American caucasian who has B27, and decreased to less than 10% if the patient lacks B27. It should be appreciated that the power of the association of B27 with ankylosing spondylitis is the premier example for utility of HLA association. Unfortunately, there are no other associations which are as strong as this, and only a small number which even approach it. Consequently, the clinical use of HLA testing in unselected patients has little, if any, justification. However, in selected patients it can be very informative.

With apologies for a certain degree of arbitrary selection, it is worthwhile to present a current listing of interesting associations between certain diseases and various HLA antigens. This listing will be categorized by HLA antigens rather than by organ systems. In the A series of antigens the primary and virtually sole association is that between A3 and idiopathic hemochromatosis. Approximately 75% of patients with this disease will have A3 compared to roughly 30% of normal controls. The RR for hemochromatosis in persons having A3 is approximately 9.5. As mentioned earlier, idiopathic hemochromatosis is linked to HLA, and it is believed that the uniquely high frequency of A3 represents linkage disequilibrium for this particular HLA allele and the disease. Another but weaker association for an A series antigen has been found for A28 and the development of head agglutinating anti-sperm antibodies following vasectomies.

Among the B series of antigens B27 is the antigen associated with the seronegative arthropathies, namely, ankylosing spondylitis with an RR of approximately 150, Reiter's disease with an RR of approximately 36, and post-infectious arthropathies due to *Salmonella*, *Shigella* and *Yer-*



sinia with an RR of approximately 20. A number of interesting variations on the B27 association have been found which include the previously noted differences in susceptibility based on the race of the individual having B27, the influence of sex on the expression of the disease, and the added risk attributable to homozygosity for B27.<sup>27,28,32</sup>

The other major B series antigen with strong disease interactions has been B8 which has associations spanning a number of organ systems including the endocrine, gastrointestinal, hematologic, neurologic and connective tissue disease categories. The types of diseases involved in these organ systems are generally characterized by abnormal antibody production with autoimmune characteristics. The mechanism for this B8 relationship and the exuberant antibody production is not precisely defined but may indicate a lack of suppressor activity and/or an exaggerated influence of T helper cells. The diseases which have the strongest association with B8 are gluten sensitive enteropathy in which approximately 80% of the patients have the antigen with an RR of 8.8, dermatitis herpetiformis with an RR of approximately 9.2, myasthenia gravis with an RR of 4.4, Sjogren's syndrome with an RR of approximately 3.0, chronic active hepatitis with an RR of approximately 3.0, thyrotoxicosis in caucasians with an RR of 2.5, juvenile diabetes mellitus with an RR of about 2.1, and systemic lupus erythematosus with an RR of 1.9.

Diseases associated with Bw35 include mitral valve prolapse with an RR of 3.4, IgA nephropathy with an RR of 3.9, and a strikingly high RR of 22 for an association with subacute thyroiditis. An antigen that cross-reacts with Bw35, namely HLA-B5, has been found to have a strong association with Behcet's disease and has occurred in more than 80% of those with the complete syndrome and in about 60% of those with the incomplete syndrome.

Associations with C series antigens have been few, primarily because the full array of C series antigens is not completely defined and reagents for testing the known ones are scarce. However, psoriasis vulgaris has been shown to have a strong association with Cw6 that occurs in approximately 48% of affected individuals compared to 15% of controls for an RR of approximately 5.

The antigens of the DR series are currently the most actively investigated HLA antigens for disease associations. Once again, this series of antigens is not completely defined, and only a small number of diseases have shown significant associations. For example Goodpasture's syndrome has a strong association with DR2, as does mul-

tiples sclerosis, optic neuritis, and systemic lupus erythematosus. DR3 associated diseases include, partly because of the linkage disequilibrium between B8 and DR3, a number of those which have already been mentioned for their B8 association. Thus the DR3 association list includes gluten sensitive enteropathy, dermatitis herpetiformis, chronic active hepatitis, Sjogren's syndrome, juvenile diabetes mellitus, thyrotoxicosis, myasthenia gravis, and juvenile rheumatoid arthritis.

Adult rheumatoid arthritis is the key disease associated with DR4, although diabetes mellitus also has a strong association with DR4, just as it does with DR3. Hydralazine induced lupus is also associated with DR4.

DR6 associated diseases include IgA nephropathy, idiopathic hemochromatosis, and cryptogenic fibrosing alveolitis.

### Paternal Testing

Since Terasaki's publication of 1,000 cases of paternity testing in which the putative father was not excluded on the basis of ABO testing, there has been a sharp rise in the application of HLA testing to paternity.<sup>33</sup> This has been accompanied by a steadily increasing number of states introducing legislation to allow HLA testing to be admitted not only as exclusionary evidence but also as a means of estimating inclusion probabilities. This area alone could involve a long treatise, but suffice it to say that paternity testing must include information describing the chain of evidence, identification of the parties tested, performance of the test in duplicate, a high standard for the laboratory performing the tests, availability of individual antigen and haplotype frequencies for the appropriate race, and an acceptable method for calculation and expression for the results.

### Final Comments

Studies of the HLA system and MHC in man have contributed a great deal to the clinical areas of organ transplantation and paternity testing. Although their clinical contribution to disease susceptibility is limited at the present time, the potential that they have for identifying at least some of the major genetic controls of disease susceptibility and resistance, as evidenced by their strong analogies with the mouse MHC, appears to offer the greatest rewards. ◀

### References

A complete list of references for "Clinical Applications of HLA Testing," from the Seminars in Immunopathology and Oncology column may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago IL 60603.

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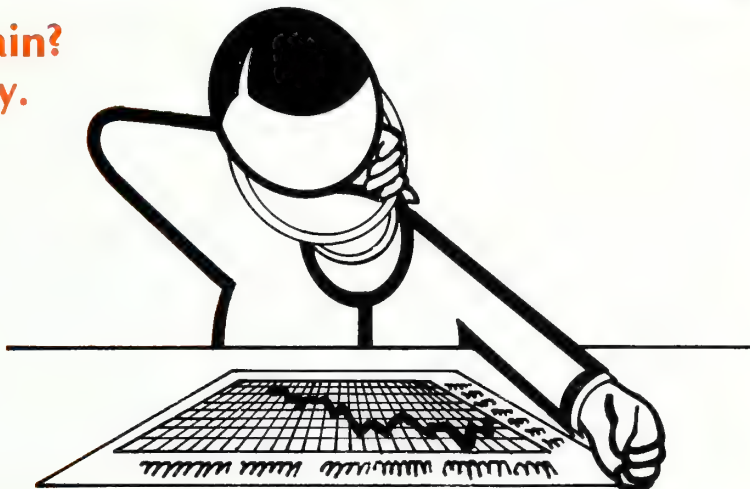
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**RECEIVABLES.** There are advantages to having an attorney handle your past due accounts. To discuss these advantages and your receivable problems call M. Turek, attorney specializing in Creditor's Rights, (312) 951-8515.

**STEAMBOAT SPRINGS, COLORADO.** Current Concepts in Pain Management. Guest may attend associated tax program (expenses deductible). January 8-14 and February 28-March 4, 1983, \$250 (guest \$100), Contact D. Bernan, M.D., Program Director Current Concept Seminars, 3301 Johnson St., Hollywood, FL. 33021. (305) 989-6650.

**CERTIFIED PHYSICIAN ASSISTANT** with postgraduate surgical specialty from Norwalk/Yale residency program desires position with surgeon in Chicago area for July, 1983. Experience includes thoracic and vascular surgery (Scripps Clinic) and cardiovascular surgery (UCLA). Contact Dr. James Mayes (714) 450-0168 or (714) 455-9100 Ex. 8256.



# Illinois Society, American Association of Medical Assistants

## The Belleville Area College Medical Assisting Program

BY ROSE M. HALL, R.N., CMA-AC

Belleville, a city of approximately 45,000 near St. Louis, is the site of Belleville Area College, which has supported a medical assisting program since 1971. It is an innovative, unique one-plus-one course.

After completion of the one-year program, students have the basic entry level skills to obtain employment in a medical office or facility. The student then may choose to complete the second year and increase clinical specialty skills and management knowledge.

Graduates have been employed in many different areas of the health care field: medical offices, medical school clinics, and administrative offices of medical associations. In hospitals they may work in the medical transcription department, the X-ray lab, with EKG's or on the floor. Other graduates have opted to work in the insurance industry or for companies that supply medical facilities. A few graduates continue their education to work as nurses or become health occupation educators.

The medical assistant curriculum begins with basic courses in anatomy and physiology, medical terminology, typing and business machines. The student is then introduced to administrative skills such as appointment scheduling, reception techniques, phone communications, maintenance of the medical records, filing methods and CPT-4 coding. In the laboratory, the student is required to demonstrate competency in venipuncture and completion of a CBC, manual and automated.

A course on medical law and ethics is also included. This class outlines the responsibility of the medical assistant. Another course stresses oral communications.

In the second semester the student is introduced to basic bookkeeping procedures and banking and insurance forms with additional coding. A course on medical transcriptions uses actual medical tapes, including X-ray transcriptions, histology reports, administrative notes, and consultation in such specialties as surgery, endocrinology, gynecology, dermatology, neurology and car-

diology.

The student is taught to recognize vital signs, care of equipment, sterile technique and use of sterilizers, emergency care and CPR. Injections are also taught as part of the curriculum, but whether this skill is used is up to the individual employer.

Other skills learned are urinalysis and use of automated equipment for blood chemistries, throat cultures, pregnancy tests and prothrombin times. Basics of X-ray generation, safety, developing and care of cassettes are included.

During summer months, students participate in externships. Working three days a week for eight weeks under the supervision of medical office personnel, students are exposed to the administrative and clinical tasks in an office setting. A clinical coordinator is in contact weekly with the office or is available to the student in an emergency.

Following the first year of the program, which begins in August and ends in July, students receive a certificate and may take the National Certification for Medical Assistant examination. Surveys show that graduates of the basic one-year program become productive within two weeks of employment. Following the second year of the program, which can be taken at night, students receive an associate of applied science degree.

The medical assistant's career is a full time, rewarding profession for the majority of graduates. Assistants are aided in continuing their professional growth by their professional organizations which provide continuing education programs. The program also receives community input through an advisory committee consisting of graduates of the program, certified medical assistants and physicians. This committee reviews the curriculum and identifies future trends to include in the program.

Further information regarding this program can be obtained from Rose Hall, R.N. CMA-AC, coordinator-instructor, Medical Assistant Program, Belleville Area College, Belleville, IL 62221. ◀

**Blue Cross®  
Blue Shield®**



# REPORT

## FOR *Illinois Physicians*

### NEW MEDICAL DIRECTOR NAMED

Ronald A. Ferguson, M.D. has been named Vice President and Medical Director for Blue Cross and Blue Shield of Illinois, effective Oct. 1, 1982.

Dr. Ferguson, 42, was vice president of the Department of Family Planning at Columbus-Cuneo-Cabrini Medical Center and Co-Director of the Section of Family Medicine



DR. FERGUSON

at Northwestern University Medical School. He was also an Assistant Professor of Clinical Community Health and Preventive Medicine at Northwestern.

A native of Canada, Dr. Ferguson received both his Bachelor of Science and Medical degrees from Queen's University, Kingston, Ontario. Upon completion of his internship and residency in internal medicine in 1968, Dr. Ferguson practiced general medicine in Whitehorse, Yukon Territory, and in North Bay, Ontario, before joining the faculty of Southern Illinois University, at Springfield and Carbondale, in 1975. He was Director of the School of Medicine's Family Practice residency in Carbondale until he moved to Chicago in 1978.

Dr. Ferguson is a member of the American Medical Association, the Illinois State Medical Society, the Chicago Medical Society, the American Academy of Medical Directors and other professional organizations.

### FALL WORKSHOP SERIES SCHEDULE

The Illinois Blue Cross and Blue Shield Plan's Fall Workshop series for medical assistants in the Chicago and Metropolitan areas are now underway. The majority of meetings are being held in the Blue Shield Auditorium at 2 Illinois Center.

The workshops are intended to inform medical assistants in Plan administrative, claims and payment procedures and advise them of changes in Blue Shield benefits and contracts.

For further information, please call (312) 938-7887.

Following is a workshop schedule:

Wednesday	October 6, 1982	Blue Shield Auditorium	1 p.m. to 4 p.m.
Thursday	October 7, 1982	Blue Shield Auditorium	9 a.m. to 12 p.m.
Wednesday	October 13, 1982	Blue Shield Auditorium	9 a.m. to 12 p.m.
Wednesday	October 13, 1982	Joliet Holiday Inn South I-80 to Larkin Road	9 a.m. to 12 p.m.
Thursday	October 14, 1982	Blue Shield Auditorium	1 p.m. to 4 p.m.
Wednesday	October 20, 1982	North Aurora Holiday Inn 311 S. Lincolnway	9 a.m. to 12 p.m. 1 p.m. to 4 p.m.
Wednesday	October 27, 1982	Blue Shield Auditorium	9 a.m. to 12 p.m.
Wednesday	October 28, 1982	Elgin Holiday Inn 345 West River Road	9 a.m. to 12 p.m. 1 p.m. to 4 p.m.
Wednesday	November 3, 1982	Blue Shield Auditorium	9 a.m. to 12 p.m.
Thursday	November 4, 1982	Blue Shield Auditorium	1 p.m. to 4 p.m.
Wednesday	November 10, 1982	Blue Shield Auditorium	1 p.m. to 4 p.m.
Thursday	November 11, 1982	Blue Shield Auditorium	9 a.m. to 12 p.m.



# Health Cost-Cutting Grants Total \$462,000

Blue Cross and Blue Shield of Illinois has awarded \$462,000 in grants and interest-free loans to eight agencies and institutions in the state for health-care cost containment projects.

Ronald D. Osborne, Blue Cross and Blue Shield Plan vice president, said the awards came from a \$1 million fund established one year ago to spur cost savings innovation in health care.

"The savings on these projects are estimated at \$13 million annually. In the long term, savings on many of these programs would multiply as they are adopted elsewhere in the state," Osborne said.

The grants and loans are available to non-profit agencies and institutions throughout the state. Awards are approved by committees representing the health care professions, Blue Cross and Blue Shield and the general public. About three-quarters of the funds awarded so far have been grants, with the remainder in interest free loans.

Osborne said the fund was originally budgeted for a two-year period, but that renewal is possible. "By this time next year, many of these programs will be in full operation, and we will be able to review concrete results."

## Among the Awards Approved Thus Far Are:

—A \$74,000 grant to Highland Park Hospital and other north suburban facilities for a feasibility study of a shared data center, leading to the purchase of one computer system instead of separate purchases by each hospital. The savings estimate is at least \$2.2 million, and possibly as much as \$10 million.

—A \$69,800 grant to the Chicago Health Systems Agency's Center for Health Systems Development for a health facilities plan for Chicago. The agency will make recommendations for hospital mergers based on financial and architectural assessments. The savings potential is

estimated at \$1.8 million annually.

—A \$20,000 grant and loan to the Springfield-based West Central Illinois Health Systems Agency for establishment of an audio-visual library for continuing education for health care personnel. The audio visual programs would save work time and travel costs to continuing education seminars and save an estimated \$64,000 annually.

—A \$77,631 grant to Southern Illinois University's department of family practice, Springfield, for development of a curriculum stressing cost consciousness among physicians and medical students. Just one method already developed for one ailment has enabled a single physician to save \$882,000 a year in patient costs, according to University officials.

Osborne said other projects range from development of new prescription strategies to expansion of shared services and group purchasing arrangements among health care facilities.

"We are excited about the projects already funded and are convinced that our investment in them will pay off in lower health care bills. We are also looking forward to receiving even more new ideas of this type in the year ahead," Osborne said.

## Change Made in Claims Billing

Prior to the merger of the Rockford and Chicago-based Blue Cross and Blue Shield Plans, a number of Central Certification Groups were enrolled with the Rockford Plan. Claims for these groups were mailed to the Rockford Blue Cross office for processing.

Effective August 1, 1982, all services incurred on or after August 1, 1982, for these groups, should be filed with the Chicago office. These claims should be billed on a Chicago Blue Shield claim form - "Physicians Service Report Form" - and mailed to Illinois Blue Cross and Blue Shield Plan, 233 N. Michigan Avenue, Chicago, Illinois 60601.

If claims with services after August 1, 1982, are filed with the Blue Cross office in Rockford, there will be an approximate one week delay in claims processing as the claims will be transferred to the Chicago office.

The following Central Certification Groups were processed most frequently by the Rockford office:

GROUP	GROUP NUMBER
I.B.M.	90600
American Dist. Telegraph	ADT303
Coopers & Lybrand	CNL303
Westinghouse Electric	WXB363

GROUP	GROUP NUMBER
D.C.A. Foods, Inc.	DCF303
General Electric	GEC200
S.S. Kresge Co.	SSK210

These groups as well as all other Central Certification Groups will now be processed in the Chicago Blue Cross and Blue Shield Office.

If you have any questions concerning this procedure, contact the Professional Relations Department at (312) 938-7059.

## Reminder

Following is a reminder on some of the unique features of the State of Illinois employees insurance program:

### Outpatient Surgical Procedures

The State of Illinois program includes a list of surgical procedures which must be performed on an outpatient basis. If any of these procedures are performed on an inpatient basis, documentation supporting the medical necessity of the inpatient surgery must be attached to the claim at the time of submission. If the appropriate documentation is not attached, the claim will not be processed but returned to the provider for proper documentation.

Refer to "Blue Cross and Blue Shield Report for Illinois Physicians" in the November, 1981, issue of the **Illinois Medical Journal**.

### Filing of Claims

All claims must be submitted no later than one (1) year from the ending date of the contract period in which the charge was incurred, as follows:

Claims with Service Date	Final Filing Date
July 1, 1981 thru June 30, 1982	June 30, 1983
July 1, 1982, thru June 30, 1983	June 30, 1984

If you have any questions concerning the above, please contact your Professional Relations Representative.

# Medicaid-Medicare-Champus Report

## IDPA Issues Revised MMIS Guidelines

Subsequent to a series of negotiations between ISMS and the Illinois Department of Public Aid, the Department has agreed to revise its guidelines on billing for consultation and concurrent care. The new guidelines, which have been mailed to all physicians who are currently enrolled in IDPA'S Medical Assistance Program, became effective September 15, 1982.

**Consultation:** Previously, IDPA guidelines allowed reimbursement only for a single consultation to be performed at the request of the attending physician. If the consultant continued to provide follow-up care, IDPA either reduced the consultation to an initial office or hospital visit or sought to deny any reimbursement for care provided by the consulting physician after the consultation was performed. The revised guidelines will now allow the Department to reimburse physicians who bill for consultations regardless of subsequent office or hospital visits, if additional documentation is submitted to IDPA by the consulting physician to justify subsequent visits. This article will briefly outline the new IDPA guidelines for consultation and concurrent care.

IDPA will still consider, for payment purposes, that a consultation is the entire package of physician services required to arrive at a recommendation concerning a patient's condition and a plan of treatment. However, under the new guidelines, if a consultant assumes the continuing care of the patient or is required to provide follow-up visits, he should bill IDPA using the appropriate subsequent office or hospital visit procedure code.

When a patient's condition necessitates more than one subsequent visit by the consultant, the consulting physician should include a copy of the consultation report and a narrative description of the patient's condition identifying reasons for the follow-up visits.

As a result of these negotiations between ISMS and IDPA, the Department has also revised its record keeping requirements for consultations. The description and specific record keeping requirements for each level of consultation exactly parallel the criteria for the levels of consultations as outlined in the AMA's *Current Procedural Terminology*, fourth edition. Physicians who submit MMIS claims for consultations should continue to report the appropriate CPT IV procedure code in Box 24-C on the MMIS claim form.

The Department will continue to consider a presurgical examination by the surgeon and/or anesthesiologist as an essential element of the surgery. Except in emergency or traumatic situations, IDPA will not reimburse for presurgical examinations and a consultation.

Finally, if the consultant and attending physician continue to provide follow-up care, the Department will consider these cases to be concurrent care situations. The section on concurrent care (below) will describe how IDPA will consider reimbursement for continuing care by two or more physicians.

**Concurrent Care:** As a result of revisions to IDPA's consultation guidelines, the Department also reconsidered its position on concurrent care. Frequently, in concurrent care situations (two or more physicians providing care to the same patient), the Department only reimbursed the physician who submitted a claim for services before the other physicians submitted their claims. The only exception to this provision was for extreme emergencies or life threatening situations.

A concurrent care situation will occur only in a hospital setting. The physician who initially provides care should continue to submit claims for his services as the attending physician using the appropriate CPT IV procedure codes. The physician(s) who provide care or treatment concurrently are to submit claims for their services by entering the letter I (alphabetical not numerical) in the Type of Service Section (Box 23-E) of the MMIS claim form. This alphabetical notation on the claim identifies the service as concurrent care and will be reviewed for payment by IDPA.

The Department will screen concurrent care claims based on several criteria. The Department will review each claim for concurrent care based on the complexity and severity of a patient's medical condition which necessitates treatment by more than one physician. In all cases of concurrent care, the Department will screen the medical specialties of the physicians who are treating the patient. IDPA will *rarely* consider reimbursement for concurrent care when the physicians who treat the patient are of the same medical specialty.

The physician who submits a claim for concurrent care services must append a narrative statement which describes the patient's medical condition and a copy of the hospital discharge summary with the MMIS claim. If a consultant is providing follow-up care concurrently with the attending physician, a copy of the consultation report must also accompany the claim with the documentation described above. Finally, IDPA will require that all claims for services rendered concurrently include the *specific ICD-9-CM diagnosis code* in Box 23-D on the MMIS claim form. When a physician submits a claim for concurrent care he *can not* report diagnosis code 9999 (unlisted diagnosis) in Box 23-D on the MMIS claim form.

The Department will not reimburse teaching or supervising physicians for concurrent care.



**Recipient Utilization Review Program (RURP):** ISMS staff have recently received inquiries from physicians concerning IDPA's Recipient Utilization Review Program. The Department instituted the Recipient Utilization Review Program in an effort to identify recipients whose utilization of medical services is significantly high. Those recipients who are determined to be overutilizing medical services are informed by IDPA that they may jeopardize their eligibility for medical assistance unless utilization of those services is limited to services that are medically necessary. The recipient is counseled and assisted by an IDPA caseworker to develop a plan to reduce the overutilization of medical services. However, if IDPA determines that a recipient continues to overutilize medical services, the Department will require that medical assistance eligibility be dependent upon the recipient being "locked in" to a primary care physician. A primary care physician is a physician who agrees to act as the "gatekeeper" for the recipient's access to all referral and specialty services. Once IDPA recommends a recipient for participation in the Recipient Utilization Review Program, all non-emergent physician, lab, X-ray, clinic, drug and eye care must be provided or referred by the primary care physician. Patients who have been restricted to a primary care physician under RURP can be identified by a notation on the front side of the IDPA Medical Assistance Program "green card." The restriction code "E" (front side of card) will appear in the "Program Restriction Message" (lower left corner)— area of the "green card." In addition, the name of the primary care physician who must perform or refer services will also be identified on the "green card."

The primary care physician voluntarily agrees to participate in this program. A physician who provides care who is not the recipient's primary care physician *will not be reimbursed* by IDPA without the referral that is approved by the primary physician. The authorization for services should be signed by the primary care physician and submitted to IDPA with the claim for services by the physician who performs the medical services.

The approval for referred services under the RURP is IDPA form 1662 and is obtainable from the primary care physician.

**New Error Codes:** ISMS staff is aware that many physicians' MMIS claims are being suspended in the IDPA claim processing cycle for prepayment reviews. In an effort to more fully explain the reasons for physician claims that are suspending for a prepayment review, IDPA has developed several additional error codes and error messages that will begin to appear on MMIS Remittance Advice Sheets for claims processed after August 23, 1982.

Physicians whose MMIS claims are suspended for one of the reasons listed below, should not resubmit the claim. A final adjudication of the claim will be reported on a future Remittance Advice Sheet once IDPA completes the review.

<u>Error Code</u>	<u>Error Message</u>	<u>IDPA's explanation of the error message</u>
X-51	Review of Initial Office Visit Charge	A charge was submitted for an initial Office Visit which, according to Department records, has previously been paid to the physician or another associate in his group practice.
X-52	Review of Consultation	A charge was submitted for previously paid consultation.
X-53	Review of Hospital Visit	A charge was submitted for a hospital visit previously billed by another physician.
X-54	Review of Visit/ Surgery/Procedures	A charge was submitted for a procedure/visit that was previously billed—not paid.
X-55	Review of Maternity Care	A charge was submitted for a constituent part of the total OB/care package.
X-56	Review of Surgical Procedure	A charge was submitted for a surgical procedure (one time only procedure) previously paid.
X-57	Review of Lab Procedure	A charge was submitted for a constituent part of a previously paid laboratory panel/profile.
X-58	Review of X-ray Procedure	A charge was submitted for a constituent part of an X-ray procedure.

ISMS will continue to provide updates on changes to the MMIS program through *IMJ*. Physicians who require assistance with MMIS claim processing should contact their ISMS Field Representative at 312-782-1654.

# President's Page

## Exemption From Medical Society Dues



Like most voluntary associations, ISMS is entirely dependent on membership dues to fund the multiplicity of services it performs. Funds derived from dues permit the Society to provide services for its members, and also, to a considerable extent, for the benefit of all the physicians practicing in this state and for the better health of the citizens of Illinois.

The Society recognizes, however, that many members have been faithful to it over an extended period of time and wishes to demonstrate its appreciation for this to them. In these instances, ISMS will continue their membership and all the attendant benefits and privileges, without requiring continued payment of membership dues. It also recognizes that, generally, a physician's income is reduced following retirement and will continue a retired physician's membership without requiring payment of any dues.

The Finance Committee dissects the Society's annual budget with a very sharp scalpel. Still, the fact remains that, in this inflationary age, professional dues and assessments are distressingly high. Sometimes, they may be beyond the financial capability of an individual. ISMS is reluctant to lose a valued and respected physician as a member for this reason and under certain circumstances, may consider waiving a member's dues.

Below is a summary of the categories of membership in which no dues are required of a member of ISMS:

*Emeritus Members*—Those physicians who have been members in good standing for 35 years and have reached or will reach the age of seventy before the end of the year; and who have made written application to the county society; and have been recommended to the state society for this status. Such membership shall be effective January first of the year following election.

*Retired Members*—Those who have been regular members and who by reason of age or incapacity have retired from practice and who upon application and recommendation from their county society have been accorded retired status. Retired status should be withdrawn if the physician receives compensation for medical services.

*Waiver Members*—Upon recommendation of the county society, the Board of Trustees may authorize dues waived for members for any good reason. Usually the reasons for dues waived are financial difficulties or practicing medicine in another country on a temporary basis. Waived dues must be approved by the county and state on an annual basis.

*Military*—ISMS requires no dues; AMA, however, requires a \$210 dues payment.

A handwritten signature in dark ink, reading "C. C. Wiggishoff M.D.".

Cyril C. Wiggishoff, M.D., President



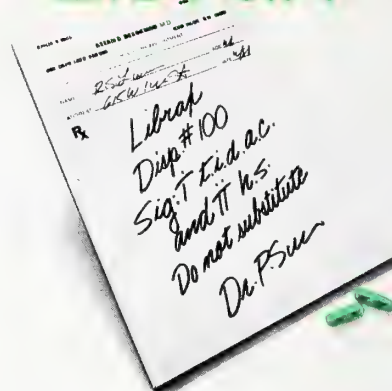
## Clinics for Crippled Children Listed for November

Forty-two clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 27 general clinics, 11 cardiac clinics, one for children with neurological problems, 1 for children with scoliosis and 2 for children with myelodysplasia. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- 1 Peoria Myelodysplasia - St. Francis Medical Center
- 2 Pittsfield - Illini Hospital
- 2 Wheaton - Marianjoy Rehabilitation Hosp.
- 2 Park Ridge General - PM - Lutheran General Hospital
- 2 Park Ridge Cardiac - AM - Lutheran General Hospital
- 3 Cairo - Southern Seven Health Dept.
- 4 Springfield General - Memorial Med. Bldg.
- 4 Sterling - Community General Hospital
- 4 Effingham - St. Anthony Memorial Hosp.
- 4 Lake County Cardiac - Victory Mem. Hosp.
- 4 Hinsdale - Hinsdale Sanitarium
- 5 Division Cardiac - U. of I. at the Medical Center
- 8 Peoria Cardiac - St. Francis Med. Center
- 8 Maywood - (Ortho/Ped/Neuro) - Loyola Medical Center
- 8 Chicago Heights Cardiac - St. James Hosp.
- 9 East St. Louis - Community Hospital
- 9 Peoria General - St. Francis Medical Ctr.
- 10 Rockford - St. Anthony Hospital
- 10 Champaign-Urbana - McKinley Health Service Center
- 10 Joliet - St. Joseph's Hospital
- 10 Chicago Heights General - St. James Hosp.
- 10 Aurora MM - Mercy Center for Health Care Services
- 11 DuQuoin - Marshall Browning Hospital
- 11 Aurora Cardiac - Mercy Center for Health Care Services
- 11 Kankakee General - St. Mary's Hospital
- 12 Hinsdale Scoliosis - Hinsdale Sanitarium
- 15 Maywood (Ortho/Ped) - Loyola Med. Ctr.
- 16 Rock Island General and CP - Moline Public Hospital
- 16 Decatur - Decatur Memorial Hospital
- 16 Belleville - St. Elizabeth Hospital
- 17 Springfield Ped-Neuro - Memorial Medical Building
- 17 Elgin - Sherman Hospital
- 17 Evergreen Park - Little Company of Mary Hospital
- 18 Centralia - St. Mary's Hospital
- 18 Champaign Children's Home - Champaign
- 18 Elmhurst Cardiac - Memorial Hospital of DuPage County
- 19 Kankakee Cardiac - St. Mary's Hospital
- 22 Peoria Cardiac - St. Francis Med. Ctr.
- 22 Chicago Heights Cardiac - St. James Hosp.
- 23 Peoria General - St. Francis Med. Center
- 29 Peoria Cardiac - St. Francis Med. Center
- 30 Alton - Alton Memorial Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

# Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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Please see summary of prescribing information on facing page.



# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This month's Viewbox was prepared by Curtis Poor, M.D., department of radiology, Loyola University Medical Center, Maywood.*

*This 33-year-old woman had an automobile accident and has continued pain of the right hip following reduction of a posterior dislocation. Figure 1 is an AP view of the hip.*



**Figure 1**  
**AP view right hip.**

## ***What is your diagnosis?***

- (1) Loose body in joint space
- (2) Dislocated hip
- (3) Acetabular fracture
- (4) Normal
- (5) Avascular necrosis

## ***What study would be most valuable if this early traumatic hip problem is unresolved following clinical evaluation and plain radiographs?***

- (1) Radionuclide bone scan
- (2) Plain tomograms
- (3) Computed tomography
- (4) Arthrography

*(Continued on page 365)*

# Where can you match up with pressure pads, stretcher pads and surgical pads?

## The new Health Care Industry Directory

Match up with everything from acid proof equipment to X-ray tubes without leaving your office. This new directory puts manufacturers, wholesalers, distributors, fabricators, equipment services and suppliers right at your fingertips. No other source can match you up with so much, so fast.

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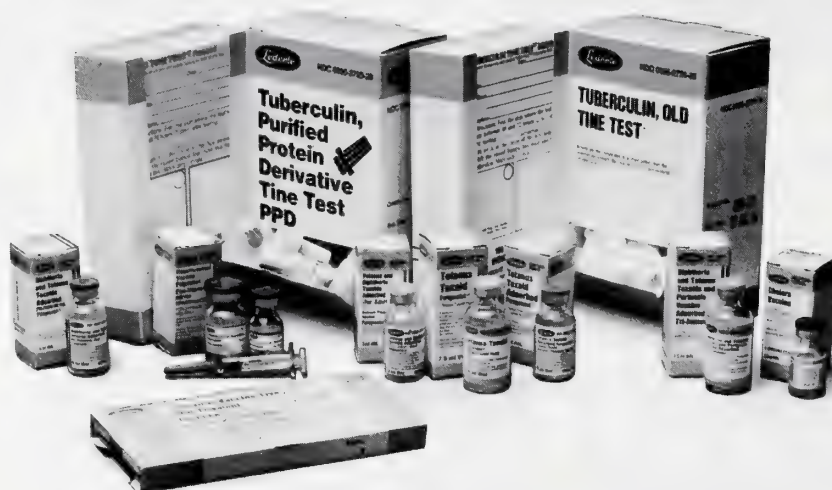
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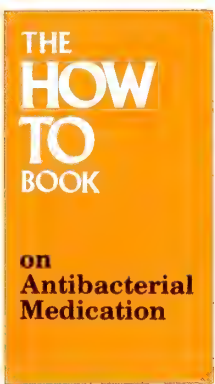
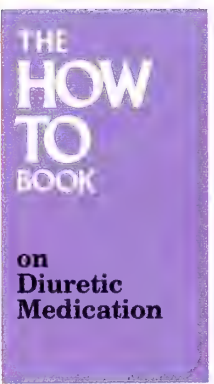
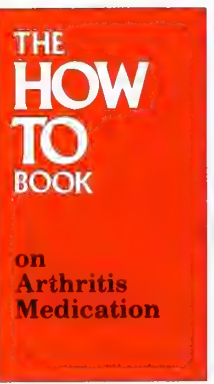

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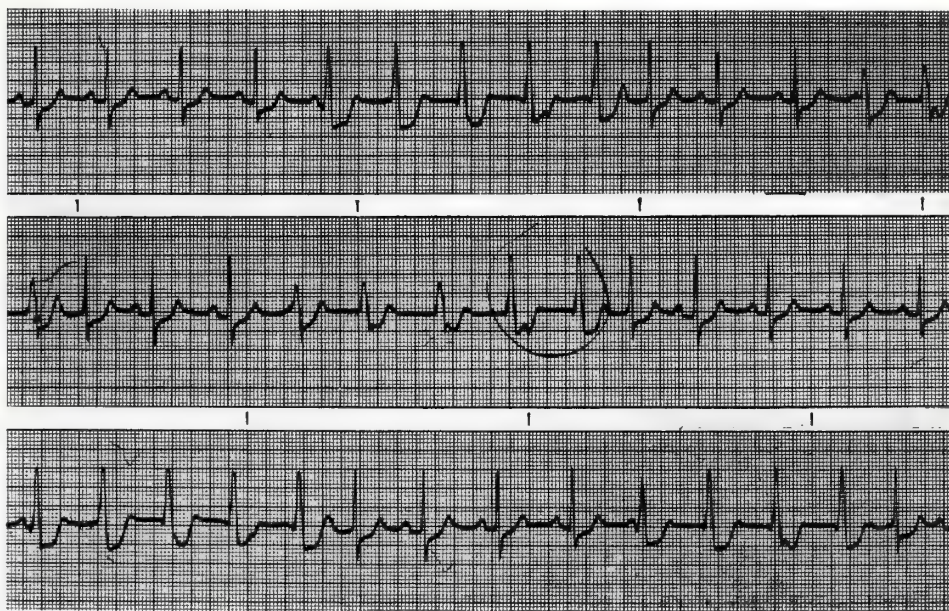
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# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a fifty-three year old man who was in good health until the evening of admission. At supper, he had a sudden onset of crushing, nonradiating chest pain associated with nausea, vomiting, diaphoresis, and pallor. He became light-headed and collapsed. Paramedics were called and brought him to the emergency service. He never lost consciousness. In the emergency room his blood pressure was 110/70mmHg. Examination of the lungs showed bibasilar fine crepitant rales. There was an atrial gallop on examination of the heart. The skin was cool and clammy to touch. A chest X-ray showed pulmonary vascular redistribution compatible with congestive heart failure; the heart size was normal. A twelve lead ECG was interpreted as an acute inferior wall myocardial infarction. He was transferred to the coronary care unit and a flow directed balloon catheter was placed in the pulmonary artery. The pulmonary artery pressure was 35/10mmHg and the pulmonary capillary wedge mean pressure was 15mmHg. The next afternoon, this ECG rhythm strip was obtained. The patient was asymptomatic at this time.*



## Questions:

### 1. The ECG rhythm strip shows:

- A. Cycle dependent bundle branch block.
- B. Sinus arrest or third degree sino-atrial block.
- C. Accelerated idioventricular rhythm.
- D. Paroxysmal ventricular tachycardia.
- E. Intermittent atrioventricular (AV) dissociation.

### 2. Management of this arrhythmia problem, as it is presented, could require:

- A. No treatment whatsoever.
- B. Atrial overdrive pacing.
- C. 100mg bolus of lidocaine followed by an intravenous drip of lidocaine.
- D. Direct current cardioversion.
- E. Quinidine or procainamide by oral route of administration.

(Continued on page 387)



**BECAUSE  
A THIAZIDE ALONE  
CAN ONLY DO  
SO MUCH...**

**AND YET  
CAN DO  
TOO MUCH.**



# INCREASE CONTROL WITHOUT INCREASING POTASSIUM PROBLEMS.

## **A dependable means to long-term blood pressure control.**


Many times, a diuretic alone can't keep hypertension in check. *INDERIDE*, however, can pick up where thiazide therapy leaves off.

The combination of propranolol HCl, the world's most trusted beta blocker, and hydrochlorothiazide, the standard among diuretics, enables *INDERIDE* to exert an additive antihypertensive effect.<sup>1,2</sup> In fact, a propranolol/hydrochlorothiazide regimen maintained blood pressure below 90 mm Hg in 81.8% to 86.4% of patients followed for 6 to 18 months of therapy.<sup>1</sup>

## **Low thiazide dosage means reduced risk of hypokalemia.**

When thiazides are prescribed in doses greater than 50 mg/day, the potential for hypokalemia increases substantially. What's more, the greater the fall in serum K<sup>+</sup>, the greater the risk of hypokalemia-induced PVCs.<sup>3,4</sup>

With *INDERIDE*, the additive hypotensive effect of propranolol HCl allows the effective dose of hydrochlorothiazide to be kept low (25 mg b.i.d.). And by lowering the daily dose of diuretic, *INDERIDE* also lowers the potential for diuretic-induced side effects. Potassium problems are less likely to occur—yet blood pressure can be controlled consistently.



# **INDERIDE®**

Each tablet contains *INDERAL*® (propranolol HCl) 40 mg or 80 mg, and hydrochlorothiazide 25 mg | **B.I.D. 40/25  
80/25**

## **When you know you need more than a thiazide.**

Please see Brief Summary of Prescribing Information on following page.



# INDERIDE®

Each tablet contains INDERAL® (propranolol HCl) 40 mg or 80 mg, and hydrochlorothiazide 25 mg

**B.I.D. 40/25**  
**80/25**



## BRIEF SUMMARY

(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

**INDERIDE®**  
BRAND OF  
propranolol hydrochloride  
(INDERAL®)  
and hydrochlorothiazide

No. 484—Each INDERIDE®-40/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	40 mg
Hydrochlorothiazide	25 mg
No. 488—Each INDERIDE®-80/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	80 mg
Hydrochlorothiazide	25 mg

**WARNING:** This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

**INDICATION:** INDERIDE is indicated in the management of hypertension. (See boxed warning.)

**CONTRAINDICATIONS:** Propranolol hydrochloride (INDERAL®): Propranolol hydrochloride is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

**Hydrochlorothiazide:** Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

**WARNINGS:** Propranolol hydrochloride (INDERAL®): CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely; a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA:** Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potential occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

**USE IN PREGNANCY: Propranolol hydrochloride (INDERAL®):** The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in

animal studies at doses about 10 times the maximum recommended human dose.

**Hydrochlorothiazide:** Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**Nursing Mothers:** Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

**PRECAUTIONS: Propranolol hydrochloride (INDERAL®):** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

**Hydrochlorothiazide:** Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

**ADVERSE REACTIONS: Propranolol hydrochloride (INDERAL®): Cardiovascular:** bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

**Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

**Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

**Respiratory:** bronchospasm.

**Hematology:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**Hydrochlorothiazide:** **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

**Central Nervous System:** dizziness, vertigo, paresthesias, headache, xanthopsia.

**Hematology:** leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

**Cardiovascular:** orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

**Hypersensitivity:** purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

**Other:** hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

**HOW SUPPLIED:** —Each hexagonal-shaped, off-white, scored INDERIDE 40/25 tablet is embossed with an "I" and imprinted with "INDERIDE 40/25"; contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 (NDC 0046-0484-81) and 1,000 (NDC 0046-0484-91). Also in unit dose package of 100 (NDC 0046-0484-99).

—Each hexagonal-shaped, off-white, scored INDERIDE 80/25 tablet is embossed with an "I" and imprinted with "INDERIDE 80/25"; contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 (NDC 0046-0488-81) and 1,000 (NDC 0046-0488-91). Also in unit dose package of 100 (NDC 0046-0488-99).

The appearance of these tablets is a trademark of Ayerst Laboratories. Store at room temperature (approximately 25° C).

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# Pulse of the ISMS Auxiliary

*Are You Aware . . .*

## Fetal Alcohol Syndrome

BY MRS. DONALD HINDERLITER, ISMSA PRESIDENT

There has been concern since antiquity that malformation of human growth was caused by the maternal consumption of alcohol. Seventeen years ago, it was concluded that no matter how great the amount of alcohol taken by the mother, the development of the fetus would not be affected.<sup>1</sup> There has been confusion through time as to just how alcohol did affect the fetus. However, nine years ago, during independent observations by Jones and Smith<sup>2</sup> a distinct dysmorphic condition associated with gestational alcoholism was noted and described in medical literature.

The prevention of Fetal Alcohol Syndrome (FAS) requires no scientific or medical breakthrough, only diligence and effort on the part of health professionals to make the general public aware of the problem and the solution. Through health education, this birth defect can be eliminated. Awareness must be a key word for health professionals. Those in contact with women during the phases of the childbearing cycle must have a knowledge of FAS and share this information with prospective mothers. In the prenatal period, it would be very easy to incorporate into classes the fact that there is no known safe level for alcohol ingestion during pregnancy.

Although FAS is an entirely preventable problem, it is difficult to control because identification of the alcoholic mother is difficult. Most maintain homes and raise children with varying degrees of effectiveness. If the alcoholic mother can be identified early, then preventive measures can be taken.

Incidence of FAS ranges from 1 in 600 to 1 in 1500 with estimates as high as 1 in 50 for some American Indian reservations.<sup>3</sup>

Schools provide an excellent opportunity for early education about FAS. Even grade school children can understand that alcohol is a drug that can damage the unborn baby of pregnant

women. Children might then carry the message home to mothers still in their childbearing years. Brochures or pamphlets could also be given to the children to take home. Auxilians have an excellent opportunity for intervention. Schools are always looking for information on health education.

When alcohol is abused during pregnancy, the effects of drinking are felt by the fetus, who is powerless to ward off the consequences. It is for this reason that the Fetal Alcohol Syndrome Work Group, The Illinois State Medical Society, and the March of Dimes suggest that a pregnant woman drink no alcohol during pregnancy.

Further research on the numerous physiologic, psychologic, and social disturbances associated with chronic alcoholism is also necessary.<sup>4</sup>

Health professionals caring for expectant parents or women of childbearing age, have a major responsibility in assuring the best possible outcome for mother and infant in this vital aspect of prenatal care.<sup>5</sup> Women must make their own decisions about their drinking habits during pregnancy, but health professionals have a duty to inform them of the risks. Professionals may be unable to prevent drinking in the pregnant alcoholic but they are able to confront her with the reality that drinking will most probably cause damage to her unborn child.

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# One of nature's most specific designs...

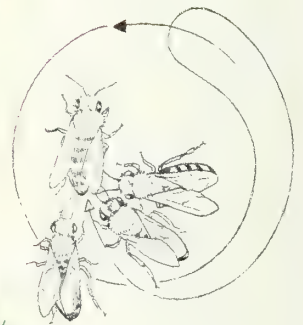
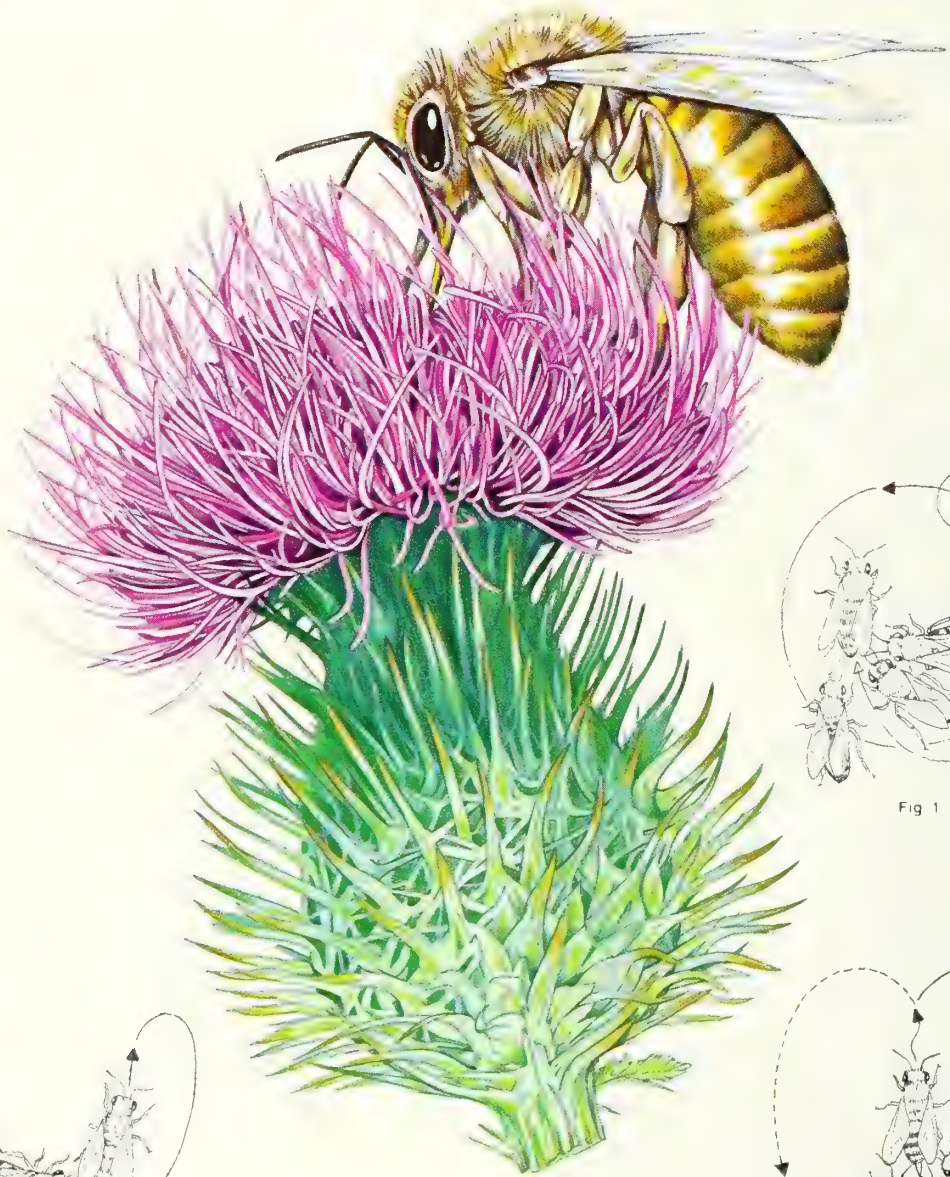


Fig 1

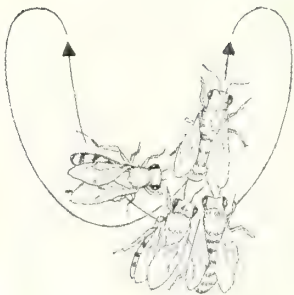


Fig 3

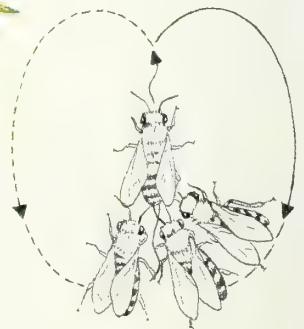


Fig 2

*Apis mellifera* Linnaeus

## BEE LANGUAGE.

The dance patterns formed by honeybees in flight are specifically designed to communicate where and how far away a source of nectar lies.

The "round dance" (Fig. 1) is a pattern of alternating circles—first to the right, then to the left, then to the right again—that lets other bees know that nectar is nearby.

Another pattern (Fig. 2) is called the "wagging dance." The bee moves forward in the direction of the nectar while wagging its bottom, then flies back to its starting place. The faster the wagging, the nearer the nectar.

The "sickle dance" (Fig. 3) is a pattern used by Italian honeybees to indicate intermediate distances. The opening of the "sickle" faces the source of the nectar; the vigorousness of the dance indicates the quality of the nectar. This degree of specificity in communication is unusual in nature.

Such specificity is almost as rare in medicine. Few agents surpass the specificity of Librium® (chlordiazepoxide HCl/Roche) for the treatment of anxiety symptoms and disorders.

Rarely affecting mental acuity at proper doses, predictable in its pattern of response, safely used in millions of patients, rapid and effective—these are the specific advantages of Librium. Caution patients about driving, operating hazardous machinery, or drinking alcohol while on Librium therapy.

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For the relief of anxiety

5mg, 10mg, 25mg capsules  
**Librium®** <sup>IV</sup>  
chlordiazepoxide HCl/Roche  
**one of man's**



## Librium® <sup>®</sup>

(chlordiazepoxide HCl/Roche)

5 mg, 10 mg, 25 mg capsules

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Known hypersensitivity to drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation, gradually taper dosage.

**Use in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety disorders and symptoms, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl/Roche) Capsules 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50 Libritabs® (chlordiazepoxide/Roche) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

## "I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

November 1	Hinsdale Sanitarium & Hosp. & A.C.S.	Hinsdale
November 1	Carle Clinic Association	Urbana
November 1	St. Theresa Area Trauma Satellite & A.C.S.	Lake Villa
November 3	Geneva Community Hospital & ACS	Geneva
November 8	Lakeview Medical Center	Danville
November 9	St. Francis Hospital & ACS	Blue Island
November 18	American Cancer Society	Chicago
December 6	Christ Hospital & ACS	Oak Lawn
December 6	ANCHOR & ACS	Chicago
December 10	Palatine Library & ACS	Palatine



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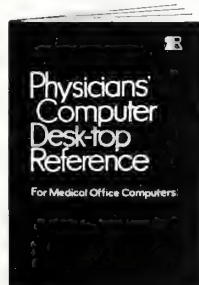
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# An added complication... in the treatment of bacterial bronchitis\*



## Brief Summary.

Consult the package literature for prescribing information.

**Indications and Usage:** Cefclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

**Lower respiratory infections**, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

**Contraindication:** Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES. Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefaclor occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

**Usage in Pregnancy**—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in terrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

**Usage in Infancy**—Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefclor.

## Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Cefclor.<sup>1-6</sup>

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.<sup>7</sup>

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship Uncertain**—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Hepatic**—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Hematopoietic**—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

**Renal**—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(1002819)

\*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

**Note:** Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

## References

1. Antimicrob. Agents Chemother., 8:91, 1975.
2. Antimicrob. Agents Chemother., 11:470, 1977.
3. Antimicrob. Agents Chemother., 13:584, 1978.
4. Antimicrob. Agents Chemother., 12:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

200066

**Cefclor®**  
cefaclor  
Pulvules®, 250 and 500 mg

# Obituaries

**\*Albert, Norman**, Johnston City, died August 29, 1982 at the age of 70. Dr. Albert was a 1939 graduate of the University of Health Sciences, Chicago Medical School.

**\*\*Davis, Loyal**, Phoenix, Arizona, died August 19, 1982 at the age of 86. Dr. Davis was a 1918 graduate of Northwestern University Medical School, Chicago.

**\*Doktor, Walter**, Chicago, died July 31, 1982 at the age of 76. Dr. Doktor was a 1936 graduate of *Akademia Medyczna Wydział Lekarski, Warszawa*.

**\*Engelbach, Friedrich**, Jacksonville, died July 25, 1982, at the age of 79. Dr. Engelbach was a 1928 graduate of Harvard Medical School, Boston.

**\*Ertl, William**, Hinsdale, died August 23, 1982 at the age of 59. Dr. Ertl was a 1946 graduate of *Orvosi Fakultás Tudományegyetem, Budapest*.

**Fields, Calvin H.**, Skokie, died July 26, 1982 at the age of 41. Dr. Fields was a graduate of the University of Iowa College of Medicine, Iowa City.

**\*Fricke, Albert**, Glastonbury, Connecticut, died August 13, 1982 at the age of 83. Dr. Fricke was a 1941 graduate of the University of Chicago Pritzker School of Medicine.

**\*Interlandi, Joseph**, Huntington Beach, California, died July 21, 1982 at the age of 61. Dr. Interlandi was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

**Knoch, Frederick W.**, Oak Brook, died July 23, 1982 at the age of 61. Dr. Knoch was a 1945 graduate of Loyola University Stritch School of Medicine, Maywood.

**\*\*Lloyd, Frederick A.**, Barrington, died August 6, 1982 at the age of 81. Dr. Lloyd was a 1927 graduate of Rush Medical College, Chicago.

**\*\*Marley, Lawrence M.**, Chicago, died August 26, 1982 at the age of 90. Dr. Marley was a 1916 graduate of the Chicago College of Medicine and Surgery.

**\*\*Metro, Michael**, Alton, died April 25, 1982 at the age of 84. Dr. Metro was a 1931 graduate of the University of Health Sciences, Chicago Medical School.

**\*\*Petter, Charles K.**, Fort Collins, Colorado, died September 3, 1982 at the age of 83. Dr. Petter was a 1928 graduate of the University of Minnesota Medical School, Minneapolis.

**Rosenstiel, Max**, Chicago, died September 9, 1982 at the age of 90.

**\*Schaffran, Morton**, Aurora, died July 17, 1982 at the age of 63. Dr. Schaffran was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

**\*Seaton, Ralph M.**, Morrisonville, died August 10, 1982 at the age of 74. Dr. Seaton was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

**\*Simpson, Raymond R.**, Alton, died June 12, 1982 at the age of 59. Dr. Simpson was a 1947 graduate of the University of Texas Southwestern Medical School, Dallas.

**\*\*Shuger, Harry**, Beverly Shores, Indiana, died August 18, 1982 at the age of 77. Dr. Shuger was a 1930 graduate of the University of Illinois College of Medicine, Chicago.

**\*Zanon, Bert, Jr.**, Chicago, died September 9, 1982 at the age of 56. Dr. Zanon was a 1951 graduate of Northwestern University Medical School, Chicago.

*\*Indicates ISMS member*

*\*\*Indicates member of the Fifty Year Club*



# ***HYPERTENSION:***



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\*Please see following page for Brief Summary of Prescribing Information.



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**BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)**  
**Inderal<sup>®</sup>** (propranolol hydrochloride)

BEFORE USING Inderal (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

### CONTRAINDICATIONS

1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

### WARNINGS

**CARDIAC FAILURE:** In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when Inderal is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levaterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA:** Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

**USE IN PREGNANCY:** Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

### PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

### ADVERSE REACTIONS

**Cardiovascular:** bradycardia, congestive heart failure, intensification of AV block; hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. **Central Nervous System:** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory:** bronchospasm. **Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

### HOW SUPPLIED

#### TABLETS

— Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).

— Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains 20 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).

— Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains 40 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).

— Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains 80 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

The appearance of these tablets is a trademark of Ayerst Laboratories.

Store at room temperature (approximately 25° C).

#### INJECTABLE

— Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).

Store at room temperature (approximately 25° C).

7997/882

**Reference:** 1 Freis, E. D. Hypertension (Suppl. II) 3:230 (Nov-Dec) 1981

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# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

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*Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**AURORA:** Dreyer Medical Clinic, S.C. Openings for Internal Medicine, Rheumatology, OB-Gyn & Urology in well established clinic of 42 physicians with associated satellite in rapidly growing area. Contact: L.E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506, 312-859-6700. (1)

**CARBONDALE:** 30 physician multi-specialty group needs pediatrician, orthopedic surgeon, radiologist. Excellent salary first year. Corporate shareholder after first year. Superior fringe benefits. University community with medical school affiliation available. All recreational facilities nearby. Contact Wayne Given, 2601 W. Main, Carbondale, 62901 (618) 549-5361 (12).

**CHAMPAIGN: FAMILY PRACTICE OPPORTUNITIES:** Set-up own practice in smaller community with business services, financial support and coverage supplied by large clinic with family practitioner members. Guaranteed income, excellent fringes, and no capital investment. Practice as you were trained. Early associateship with productivity-based income. Mr. Perkins, (217)-351-1280. (12)

**CLIFTON:** Service Area, 8,500—Immediate opening for family practitioner in rural setting. First year: guarantee, office space/staffing provided. Seventy miles south of Chicago on interstate highway. Excellent school system. Obstetrics or general internal medicine background helpful. CONTACT: George Rasmussen, Central Community Hospital, Clifton 60927. AC 815-694-2392. (10)

**DANVILLE:** Staff position available in Emergency Medicine in prestigious hospital. Annual guaranteed minimum income plus paid malpractice insurance. CONTACT: Dr. James H. Hart, Dir. ER/ St. Elizabeth Hospital, 600 Sager, Danville 61832 (12)

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**GRIGGSVILLE:** North Pike County Population 3000. Remodeled clinic available, equipped with supplies and basic equipment. Ten county physicians. Fifty miles from Quincy and 70 miles from Springfield. Recreational areas nearby. CONTACT: Harry Kopps, Box 421, Griggsville, 62340, (217)-833-2030.(1)

**MUNSTER, IND. FAMILY PRACTICE-GP's:** immediate need for primary care in large suburban multispecialty clinic. No OB. Excellent on site diagnostic available-including CT scan. 1st yr guarantee plus incentive. Partnership after 1 yr. No investment required. Contact: T. R. Hofferth, Director; Hammond Clinic, 7905 Calumet Ave., Munster, IN., 46321 (219) 836-5800 Collect. (1)

**PINCKNEYVILLE:** County Seat. 30 minutes to SIU-Carbondale. 75 minutes to St. Louis. Recent expansion of facilities provides space for a family practice physician to join three family practice physicians and a general surgeon. Lab, X-ray, and emergency room. Pharmacy on premises. Hospital one block away. Financial assistance available. Partnership status after one year. CONTACT: C. E. Cawvey, M.D., 206 North Main, Pinckneyville, 62274, 618-357-2131. (1).

**PRINCETON**—60 miles north of Peoria. Need orthopedic surgeon to join established practice. Need specialist in internal medicine. Need anesthesiologist. Twenty-three doctors on active medical staff. Stable community. CONTACT: William H. Spitler; Associate Administrator; Perry Memorial Hospital; 530 Park Avenue East; Princeton, 61356; (815) 875-2811. (12)

**ROBINSON:** Service area 20,000. 107 bed JCAH hospital in economically sound area. The hospital is currently recruiting an ob-gyn, general surgeon, orthopedic surgeon, and ophthalmologist. Comprehensive recruitment package offered includes: salary guarantee, office rent, office help and relocation expenses. Current plans include construction of a new physicians' office building. Family oriented environment. Contact Carleton King, 1000 N. Allen, Robinson, 62454. (618) 544-3131. (12)

**STERLING-ROCK FALLS:** Total population near 30,000. Two hours from Chicago, 1½ from Rockford and Peoria, one from Quad Cities. Outstanding recreational facilities. Modern 150-bed JCAH hospital; youngish medical staff, most specialties. No nurse shortage. Private or group practices. CONTACT: Darryl Wahler, CEO, Community General Hospital, 1601 First Avenue, Sterling, 61081, 815-625-0400. (1)

**STREATOR:** Otolaryngologist and neurologist needed as support to staff of 249-bed facility in North Central Illinois—Service area of 50,000—Excellent potential—Attractive office facilities close to hospital available—Financial assistance obtainable. Contact Terence Schuessler, Administrator, St. Mary's Hospital, Streator (815-673-2311). (1)



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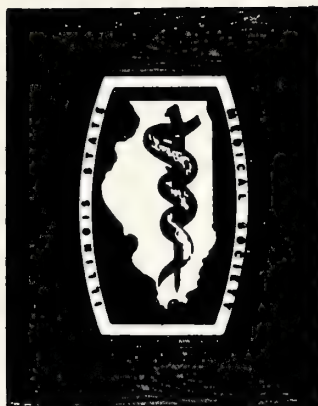
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Diplomate American Board of Radiology

**Brent M. Greenberg, M.D.**

Diplomate American Board of Radiology

**Mark Greenberg, M.D.**

Diplomate American Board of Radiology



# IMJ

*Illinois Medical Journal*

Volume 162, No. 4, October 1982

## ISMS ORGANIZATION

### History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected to fill the post in May, 1968. He was succeeded by the present executive administrator, Mr. Alexander R. Lerner, in May, 1981.

The Society published the early transactions in book form, presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention.

In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. Van Dellen was the editor for 18 years ending 1977. Subsequently, an Editorial Board was established under Chairmanship of Dr. J. William Roddick, Jr., to review and determine clinical content for the *IMJ*. The Editorial Board reports to the ISMS Publications Committee.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922, he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.



## ISMS Code of Ethics

**WHEREAS**, The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient; and

**WHEREAS**, As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals and to self; therefore be it

**RESOLVED**, That the following Code of Ethics be adopted by the Illinois State Medical Society not as laws, but standards of conduct which define the essentials of honorable behavior for the physician:

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.

3. A physician shall respect the law

and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.

4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.

7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

*Adopted by the Illinois State Medical Society  
House of Delegates  
November, 1981*

# ILLINOIS STATE MEDICAL SOCIETY

## Constitution And Bylaws

Adopted, 1903  
As Amended, 1982

### CONSTITUTION

#### ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

#### ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

#### ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

#### ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

#### ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society. Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws. Section 3. The House of Delegates shall elect members to serve on the Judicial Panel. The Judicial Panel shall perform all judicial functions on behalf of the Illinois State Medical

Society, shall review all questions of ethics and shall interpret all rules and regulations of the Society. Further, it shall conduct all hearings on appeals taken from decisions of component medical societies, arising out of disciplinary actions against physicians.

#### ARTICLE VI. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, and such trustees and other officers as the Bylaws may provide.

#### ARTICLE VII. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

#### ARTICLE VIII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

#### ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

#### ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual or interim business meeting of the House of Delegates provided that the amendment shall have been proposed at a preceding annual or interim business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.



## BYLAWS

### CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. *Regular Members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principally in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

B. *Emeritus Members.* Emeritus members are those who have been regular members in good standing for thirty-five years and have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application which is received by their component society prior to December 31 and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of the Society for at least five years.

C. *Retired Members.* Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions after retiring from medical practice.

D. *Service Members.* Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.

E. *Distinguished Members.* Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

F. *In-Training Members.* In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

G. *Student Members.* Student members are those who are currently enrolled in an Illinois medical school or are Illinois residents enrolled in an approved medical school within the boundaries of the United States, are of good moral character, professional and academic standing and student members of a component society.

Section 2. *Discrimination of Membership.* Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion, sex or ethnic origin.

Section 3. *Tenure and Termination.*

A. *Tenure of Membership.* The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership so long as he complies with the provisions of this Constitution and Bylaws. A member shall hold only one type of membership at any one time.

B. *Termination of Membership.* Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of the society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Suspension will in no way affect insurance benefits.

A member whose dues are unpaid by March 31 of the current year ceases to be in good standing and shall be notified of his delinquency by the secretary. A member whose dues or assessments remain unpaid on April 30 of the current year shall automatically be dropped from membership. An individual who has forfeited membership for non-payment of dues or assessments may be reinstated as a member before two years have elapsed, providing, in the interim, he has not been guilty of conduct prejudicial to membership, by the full payment of all dues or assessments in arrears from the date that he was last in good standing. If two or more years have elapsed since he was a member in good standing, he will be required to make application as a new member.

Any member in good standing who resigns voluntarily by December 31 of any year may be reinstated within one year of his resignation by paying all dues and assessments that fell due during the period that his membership lapsed. If more than one year has elapsed since his resignation, he must apply as a new member. Any past member who regains membership by payment of all dues and assessments in arrears shall be eligible for membership benefits only to the extent and in the same manner as a new member initially joining the society.

### CHAPTER II. DUES AND ASSESSMENTS

Section 1. *Dues.* Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois*



*Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal*. Only Regular, In-training and Student members shall be assessed annual dues. Dues for its members shall be forwarded by the component society prior to March 31 of each year.

Section 2. *Reduction and Remission of Dues*. Regular members may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. *Assessments*. In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and approved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

### CHAPTER III. EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

### CHAPTER IV. HOUSE OF DELEGATES

Section 1. *Composition*. The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, 8) one delegate elected by the Resident Physicians Section and 9) one delegate elected by the Medical Student Section.

Those having the privilege of the floor without vote are past trustees, past presidents, past speakers, general officers of the American Medical Association, members of the Illinois delegation to the AMA who are not otherwise voting members of the ISMS House of Delegates, and one representative from each member organization of the Council on Affiliate Societies.

Section 2. *Delegates*. Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. *Affiliate Group Delegates*. There shall be a Resident Physicians Section and a Medical Student Section, which shall be open, respectively, to all in-training and medical student members of ISMS. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate.

Section 4. *Time and Place of Meetings*. The House of Delegates

shall meet twice each year. These two meetings shall be designated as the annual meeting and the interim meeting. The time and place of both shall be as the House determines, except that the interim meeting should not exceed three days and its business shall be restricted in accordance with the provisions of Section 11 of this chapter. The interim meeting should be held in a district other than where the annual meeting is held. Within 100 days after the annual meeting, the Board of Trustees shall decide if there is to be an interim meeting. If the Board finds that there is not sufficient, relevant business for the House, the Board may cancel the interim session.

Section 5. *Quorum*. Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. *Special Meetings*. Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. *Registration*. Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President and/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. *District Division*. The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Order of Procedure*. The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. *Privilege of the Floor*. The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. *Introduction of Resolutions and Other Business*. All resolutions must be introduced by a voting member of the House. Resolutions submitted nine weeks prior to the annual or interim meeting of the House will be listed in the delegates handbook citing author and subject only; a full copy of all resolutions will be mailed to the delegates. Resolutions to be mailed to the delegates prior to the annual or interim meeting must be received at ISMS headquarters 30 days prior to the annual or interim meeting. Resolutions received after the above date must be approved by the Committee on Rules and Order of Business or by a two-thirds vote of the House of Delegates before they will be considered as business of the



House. The only business to be considered by the House of Delegates during an interim meeting will be:

1. Resolutions and information reports introduced by the Board of Trustees as urgent business.
2. Resolutions on matters of national importance and considered urgent introduced by a voting member of the House of Delegates on behalf of the AMA delegation under the same conditions as below.
3. Resolutions introduced by individual delegates, by the Resident Physicians Section, or by the Medical Student Section which are considered urgent and accepted by the Committee on Rules and Order of Business.
4. Decisions of the Committee on Rules and Order of Business regarding the introduction of resolutions at the Interim Meeting may be overruled by a majority of the House of Delegates. Resolutions which are not considered urgent will be carried over to the next annual meeting.

Reports of committees, councils and officers should be informational and should not contain requests for House action. Recommendations of committees, councils and officers should be submitted to the House in resolution form. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

Section 12. *Judicial Panel.* The House of Delegates shall create a Judicial Panel and shall elect five (5) of its active members to serve on the Panel, in a manner set forth in Chapter XI of these Bylaws. The Judicial Panel shall review all questions of ethics and shall interpret the laws and rules of the Society. It shall consider all questions of an ethical nature and it shall conduct hearings on appeals taken from decisions of component societies on ethical relations matters and other disputes involving the rights and privileges of physicians.

## CHAPTER V. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, twenty-one trustees and one trustee-at-large, and delegates and alternate delegates to the American Medical Association.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. *Terms of Office.* The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

Delegates and alternate delegates to the AMA shall be elected by the House of Delegates for two-year terms, except in the event of their election to fill a portion of another's unexpired term.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following

his retirement as president, he shall automatically become trustee-at-large for a term of one year.

## CHAPTER VI. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform other duties as custom and parliamentary usage may require. He shall also appoint such task forces as may be needed by the Society.

Section 2. *The President-Elect.* The President-Elect shall attend all meetings of the Board of Trustees and the Executive Committee, shall study the relationship between the Chairman of the Board and the President and shall study the responsibilities and duties of the Executive Administrator, Chairman of the Board and President so that when his term as President commences, he will have an understanding of his duties and responsibilities. He shall also serve as chairman of the Committee on Planning and Priorities.

Section 3. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice presidency, the second vice president will become first vice president.

Section 4. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 5. *The Speaker.* The Speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

Section 6. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom, or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

Section 8. *Delegates and Alternate Delegates to the American Medical Association.* Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies

established by the ISMS House of Delegates as they pertain to the AMA activities.

They shall have the privilege of the floor in the ISMS House of Delegates.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates until such time as circumstances and/or additional facts make continued effort impractical or impossible.

## CHAPTER VII. THE BOARD OF TRUSTEES

**Section 1. Composition.** The Board of Trustees shall consist of: twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. Ten trustees shall be chosen from District 3 and one from each of the other eleven districts.

The trustee districts of the Illinois State Medical Society shall be:

First District—Counties of Kane, Lake, McHenry.

Second District—Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford.

Third District—Cook County.

Fourth District—Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren.

Fifth District—Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon.

Sixth District—Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott.

Seventh District—Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby.

Eighth District—Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion.

Ninth District—Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

Tenth District—Counties of Monroe, Perry, Randolph, St. Clair, Washington.

Eleventh District—Counties of DuPage, Ford, Grundy, Irquois, Kankakee, Kendall, Will.

Twelfth District—Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago.

**Section 2. Duties.** The duties of the Board of Trustees are executive and custodial.

**A. Executive Duties.** The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority. The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

**B. Custodial Duties.** The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board. The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective. Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

**Section 3. Executive Administrator.** The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

**Section 4. Meetings.** The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

**Section 5. Organization.**

**A. Chairman.** The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

**B. Duties of the Chairman.** The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board. He supervises the work of the Executive Administrator, appoints members of councils and committees with approval of the Board, and monitors execution of Board decisions and resolutions. He may delegate any of his duties.

**Section 6. Quorum.** Eleven members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

**Section 7. County Societies.** The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

**Section 8. Publication.** The Board of Trustees shall provide and superintend the publication and distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

**Section 9. Bonding.** The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

**Section 10. Duties of Trustees.** Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least



once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem appropriate to be held in a fund of a separate incorporated entity known as "The Illinois State Medical Benevolence Fund, Inc." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. Contributions and bequests to the Illinois State Medical Benevolence Fund, Inc., shall be deposited forthwith in said fund.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

## CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district; except that district committees may be assigned to act when the Ethical Relations or Peer Review Committees of the component society fail to act as set forth in Chapters XI and XII of these bylaws.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

## CHAPTER IX. COMMITTEES

Section 1. *Committee Structure.* The committee structure of the Illinois State Medical Society shall be as follows:

- A. Councils (standing committees)
- B. Committees Reporting Directly to the Board of Trustees
- C. House of Delegates Committees
- D. Board of Trustees Committees

Section 2. *Councils.*

- A. The Medical-Legal Council shall be concerned in the areas of:
  - 1. Liaison with the Illinois Bar Association
  - 2. Liaison with courts, particularly where impartial medical testimony is involved.
  - 3. Implementation of the Impartial Medical Testimony Rule
  - 4. Legal aspects of medical practice other than in the area of mental health
  - 5. Licensing and standards of practice
  - 6. Quackery
  - 7. Anatomical gifts and organ transplants
- B. The Council on Governmental Affairs shall be concerned in the areas of:
  - 1. Federal and state legislation—analysis and communication
  - 2. Legislative liaison—both state and federal
  - 3. Political education
- C. The Council on Education and Manpower shall be concerned in the areas of:
  - 1. Liaison with medical schools, curricula, etc.
  - 2. Health manpower and training
  - 3. Internships, residencies, etc.
  - 4. Scientific assembly
  - 5. Student loans
  - 6. Continuing medical education
- D. The Council on Economics shall be concerned in the areas of:
  - 1. Ongoing relationships with third parties
  - 2. Health care cost and utilization
- E. The Council on Medical Service shall be concerned with:
  - 1. The provision of medical care and health services in the public and private sectors
  - 2. Emergency medical services
  - 3. Health care of the poor, aged and those in rural areas
  - 4. Maternal and child health
  - 5. Nutrition
  - 6. Workmen's compensation
  - 7. Environmental and community health
  - 8. Rehabilitation
  - 9. Health care facilities and delivery systems
- F. The Council on Public Relations and Membership Services shall be concerned in the areas of:
  - 1. Publicity and promotion
  - 2. News media relations
  - 3. Exhibits and public service programming
  - 4. Religion and medicine
  - 5. New member orientation and membership benefit explanation
- G. The Council on Mental Health and Addiction shall be concerned in the areas of:
  - 1. Facilities and services
  - 2. Liaison with Department of Mental Health
  - 3. Legal aspects of commitment, etc.
  - 4. Narcotics and dangerous drugs
  - 5. Alcoholism
- H. The Council on Affiliate Societies shall be concerned in the areas of:
  - 1. Liaison between the affiliate society and ISMS
  - 2. Scientific resource information and advice to ISMS

3. Consultation to other councils, e.g., postgraduate education, health care delivery, publicity, legislation
4. Advances of medical science in special fields
5. Recommendations to the Board of Trustees on legislative matters affecting any specialty society
6. Affiliate Societies
  - a. *Qualifications.* Affiliate societies shall be those recognized societies of Illinois
    1. as may be approved by the Board of Trustees
    2. which desire representation on the Council on Affiliate Societies
  - b. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

### Section 3. *Organization of Councils.*

- A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.
- B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.
- C. Members of the Illinois State Medical Society (who are not members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by the Governing Council of the ISMS Medical Student Section and resident physicians members nominated by the Governing Council of the ISMS Resident Physicians Selection may be appointed by the Board of Trustees as members of any appropriate council or committee. Such members shall be permitted full privileges of committee membership, including the right to vote. Members of the Board of Trustees may serve as advisory members to any council or committee. Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society. A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.
- D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.
- E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils and task forces, and may attend all committee meetings.
- F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.
- G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.
- H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided

all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

- I. Reports of subcommittees shall be made by the chairman to the council under which they are operating. Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council. The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard. All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

Section 4. *Task Forces.* A task force, an ad hoc body to address a specific complex issue and report by a date certain to the Board of Trustees, shall be appointed by the President upon direction of the House of Delegates or request of the Board of Trustees. It shall consist of persons from any two or more of the following categories: council members, committee members, other members of the Society, non-members of the Society. It shall be dismissed upon making its final report.

### Section 5. *Committees Reporting Directly to the Board of Trustees*

- A. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as chairman of the committee.
- B. Committee on Insurance. This committee will review society-sponsored insurance programs, study these plans, make suggestions for changes, additions and cancellation of policies, and will investigate other insurance programs that may benefit society members.
- C. Committee on Health Planning. The committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The committee shall maintain liaison with various organizations as determined by the Board of Trustees.
- D. Committee on Drugs and Therapeutics. The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.
- E. Health Data Committee. The Committee shall maintain ongoing awareness of (1) systems for the collection and dissemination of health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes, health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys. The committee shall be knowledgeable of the workings of various organizations as determined by the Board of Trustees.



- F. Peer Review Appeals Committee. This committee shall serve as an appellate body for state peer review by considering cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relation issues. The committee will serve as liaison to local peer review committees and monitors activities around the state.
- G. Committee on CME Accreditation. It shall be the responsibility of this committee to adopt necessary procedural rules and to prescribe forms to be used in the conduct of CME accreditation. The committee shall review sponsor applications and survey team reports for intrastate CME sponsors, and make decisions on grant of initial accreditation and continuation of accredited status.

Section 6. *House of Delegates Committees.* House of Delegates Committees of the Illinois State Medical Society shall be as follows:

- A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.
- B. Committee on Rules and Order of Business shall consist of five members nominated by the Speaker and confirmed by the House immediately prior to the conclusion of business at its annual meeting. The committee will serve until the next annual meeting.  
It shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates. It shall also consider late resolutions for introduction at the annual meeting and resolutions introduced by individual delegates at the interim meeting.
- C. Committee on Tellers and Sergeants-at-Arms shall:
  1. Serve the speaker of the House of Delegates.
  2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
  3. Certify those in attendance in closed or executive sessions of the House of Delegates.
- D. Committee on Constitution and Bylaws shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.
- E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.
- F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 7. *Organization of House of Delegates Committees.*

- A. Immediately after the organization of the House of Delegates at each meeting, the speaker shall announce the

appointment, from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

- B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.
- C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 8. *Board of Trustees Committees.* The Board of Trustees shall form the following committees within itself:

- A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. If the immediate past-chairman of the Board is no longer a trustee, the chairman of the Policy Committee shall be a member of the Executive Committee. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.  
The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.
- B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society. This committee shall also:
  1. Examine applications to the Society for assistance under the Medical Benevolence program to determine eligibility for assistance;
  2. Keep the names of the beneficiaries confidential and known only to the committee;
  3. Recommend the allotment for each recipient; and
  4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.
- C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.
- D. The Committee on Constitution and Bylaws shall consist

of five members—the Speaker of the House and four members appointed by the Chairman of the Board. It shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
  2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
  3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.
- E. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal*. It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content. It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies. It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal*. It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.
- F. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees. The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.
- G. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

Section 9. *Powers of the Board of Trustees.* The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 10. *Term of Membership.* The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

## CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws of ISMS and the constituent society.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Judicial Panel.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving his application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward an annual report consisting of a roster of members as of December 31 of the preceding year and a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the annual meeting.

Section 10. Any component society which fails to transmit the dues collected from its members prior to March 31 shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

Section 11. Members of the Illinois State Medical Society shall be bound by the Constitution and Bylaws of ISMS.



## CHAPTER XI. ETHICAL RELATIONS

**Part 1. *Component Medical Society.*** Each component society may have, either by appointment or election, an Ethical Relations Committee whose duty it shall be to conduct disciplinary hearings under this chapter. Although the component society may develop its own procedures for conducting such hearings, each society will, to the extent possible, comply with the general guidelines set forth by the Judicial Panel, which panel is created under this chapter; such guidelines referred to as the *Handbook for the Conduct of Disciplinary Proceedings*.

**Part 2. *District Ethical Relations Committee.*** The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Ethical Relations Committee. The component society may elect to request that the District Ethical Relations Committee, serving its area, function in its behalf and shall conduct such disciplinary proceedings as are required. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold a hearing on a properly filed complaint, within a reasonable time period, either the complaining party or the physician against whom formal written charges have been brought, may petition the Illinois State Medical Society Judicial Panel to request the District Ethical Relations Committee to intervene and take jurisdiction of the matter. In the event of a dispute resulting from such actions, the Judicial Panel shall determine, as provided in Part 7 of this chapter, the appropriate forum for the hearing.

### **Part 3. *Offenses.***

A. Disciplinary action may be taken against any member of a component society when:

1. The physician has been convicted, adjudged or otherwise recorded as guilty by any court of competent jurisdiction of a felony or a crime involving moral turpitude; or
2. He has been adjudged or otherwise recorded as guilty by his component society of:
  - a. acts of serious misconduct as a physician; or
  - b. a violation of the Constitution or Bylaws of his component society, or of the code of Medical Ethics promulgated by the Illinois State Medical Society; or
3. He has been judged guilty of a violation of a law or regulation by an administrative agency of government resulting in the termination of his privileges, license, or other rights held by the physician.

### **Part 4. *Standards and Procedures.***

- A. The committee, in its deliberations, shall evaluate acts by the standards established in the Constitution and Bylaws of the Illinois State Medical Society and/or the component medical society of which the accused is a member.
- B. Disciplinary action may be initiated by the component society or the Illinois State Medical Society upon receipt of formal written charges filed by a licensed physician practicing or residing in the State of Illinois alleging violations of any of the offenses enumerated in this Part 3. Written charges received by the Illinois State Medical Society shall be referred to the secretary of the component society in which the accused physician maintains membership or practices medicine. The component society may then exercise the choice of proceeding through its own Ethical Relations Committee or referring the complaint to the District Ethical Relations Committee. Disciplinary action may also be initiated upon the filing of a complaint of an alleged violation of any of the listed offenses by a component medical society against a physician, such complaint

having been filed by the secretary of the component society, on its behalf.

**Part 5. *Penalties.*** The component society's or District Ethical Relations Committee shall submit their recommendations for disciplinary action in writing to the component society. The recommendation shall be to: (a) acquit; (b) censure; (c) suspend; or (d) expel from membership. A decision based on a recommendation to acquit shall be final and not appealable.

The recommendation to censure shall mean an entry will be made in the accused physician's membership file to the effect that the physician has been found guilty of the act complained of and that he has been properly advised of the finding. No deprivation of membership privileges will be imposed.

The recommendation to suspend shall mean that for a fixed period of time, to be determined by the component society, the accused physician shall forfeit his rights to vote and otherwise to participate in the affairs of the local, state and national societies. In all other respects, his membership shall remain intact.

The recommendation to expel shall mean that the membership status and all privileges and rights attendant thereto of the accused physician shall be terminated for a period of one year. At the conclusion of the twelve (12) months period, the physician may re-apply for membership in the society; however, he shall then have the burden of demonstrating that the conditions and factors which contributed to his expulsion have since been removed and need not be considered in the process of reviewing his application for renewed membership.

### **Part 6. *Decision by Component Medical Society.***

- A. The recommendations of the Ethical Relations Committee must be presented to the component society for approval, rejection, modification or reconsideration. The complainant and accused shall be given reasonable advance notice of the date set for the meeting when the committee's recommendations will be considered. The complainant and the accused each may submit a written statement of their respective positions to the component society. If either the complainant or the accused feels that errors were made during the proceeding before the Ethical Relations Committee or that new and additional relevant information has become available since the committee conducted its hearing, said party shall submit a description of these errors or new evidence to the component society prior to the component society's review. At the discretion of the component society, the complainant, the accused, and their legal counsel may appear before the society to testify.
- B. If the component society believes that the new evidence not previously disclosed to the committee is relevant and material or that procedural error was committed, that component society may refer the matter back to the Ethical Relations Committee for reconsideration. The notice shall state the reasons for the referral and shall set a time limit within which a subsequent hearing must be conducted and recommendations must be presented to the component society.

**Part 7. *Judicial Panel.*** A Judicial Panel shall be created and empowered to conduct all appellate hearings arising out of Chapter XI of these bylaws and such other appellate proceedings as may derive from disputes or grievances among physicians practicing or residing in the State of Illinois. The panel shall render its decisions based on these hearings and related deliberations. The panel may, on request, adjudicate disputes among individual physicians or physician groups, between component medical societies and district Ethical Relations Committees, and between local medical societies and the Illinois State Medical Society when such disputes involve or impact the individual rights of physicians practicing or



residing in this state; except that the Judicial Panel shall have the power on its own initiative to intervene when an Ethical Relations Committee of a component medical society fails to act in a timely manner, as provided in Part 2 of this chapter. The component medical societies and District Ethical Relations Committees shall cooperate with the Judicial Panel in the collection of statistical information for the purpose of identifying the manner in which due process of law is guaranteed to physicians accused of violations of provisions of these bylaws.

The decisions of the Judicial Panel shall be final; except that an appeal may be requested by the accused member under the Constitution and Bylaws of the American Medical Association. The Judicial Panel of the Illinois State Medical Society shall confine all decisions to its proper appellate function which is to sustain, remand or overturn a decision rendered or reduce a penalty imposed by a county society or district ethical relations committee.

Members of the Judicial Panel shall be elected by a majority of the members of the House of Delegates, upon nomination by the President of the Illinois State Medical Society. The panel shall consist of five active members of the Illinois State Medical Society, elected for five-year terms on a staggered basis; except, that of the members elected to fill the initial terms on the panel, one shall be elected for an initial one-year term, one shall be elected to an initial two-year term, one shall be elected to an initial three-year term, one shall be elected for an initial four-year term and one shall be elected to an initial five-year term. Those elected to serve as members of the initial panel may be re-elected to a second full five-year term; however, succeeding members of the panel may only serve one five-year term. Those members of the Judicial Panel elected at the interim meeting in November, 1978, would serve until the next appropriate meeting of the House of Delegates.

In the event a vacancy on the Judicial Panel occurs, the President of the Illinois State Medical Society shall nominate a successor who shall serve, if approved by the Board of Trustees, until the next meeting of the House of Delegates. At its meeting following such interim appointment, the House of Delegates shall elect a member of ISMS to fill the unexpired term on the Judicial Panel by the procedure described in these bylaws.

In the event members of the Judicial Panel are unable to participate in an Appellate hearing for any reason, resulting in fewer than three members of the Panel ready and able to participate in a given appeal, the President shall recommend to the Executive Committee of the Board of Trustees and that committee shall appoint additional interim members to fill out the five-member Panel. These interim members shall serve only for the purpose of conducting and participating in the pending Appeal and their term as members of the Panel shall begin and end with the conduct of the Hearing assigned to them by the Executive Committee of the Board of Trustees. The members of the panel shall elect from among them a chairman who shall serve until his successor shall be elected by a majority of the members of the panel.

The panel shall meet as often as is necessary in order to assure a reasonably prompt disposition of matters properly placed before it and shall convene on the call of the chairman. Three members of the panel shall constitute a quorum for the transaction of its business.

The panel shall adopt such rules as it deems appropriate for the orderly conduct of its duties. A written copy of such rules shall be made available to each component society and to the chairman of the Board of Trustees. The panel shall publish a *Handbook for the Conduct of Disciplinary Proceedings*, to be approved by the House of Delegates and which shall serve as a general guideline to all component medical societies in

the conduct of hearings.

The chairman of the panel shall report to the House of Delegates at each of its annual meetings, thereby informing the members of the House of Delegates of the proceedings and deliberations of the panel during the preceding twelve months.

**Part 8. Due Process Safeguards.** In all proceedings conducted in accordance with the provisions of this chapter, the accused physician's rights to due process of law shall be honored and observed. The *Handbook for the Conduct of Disciplinary Proceedings* will set forth general guidelines for affording such due process protections.

## CHAPTER XII PEER REVIEW

**Part 1. Definitions.** Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical Society peer review shall be conducted at the local level whenever possible. Ethical relations issues identified during deliberations of the Peer Review Committee shall be appropriately referred. Peer Review Committees should apply standards developed by appropriate physician organizations; such standards to be tempered by customs and practice followed in the local community in which the evaluation is undertaken. Decisions and recommendations of Peer Review Committees shall be advisory only.

**Part 2. Component Society Procedures.**

- A. **Responsibilities**—Each component Society may have, either by appointment or election, a review committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients and, at local option, other parties. In the event a component Society shall choose not to appoint or elect its own review committee, the component Society may, by action of a majority of its members eligible to vote, delegate the peer review functions to an appropriate physician organization competent to perform these functions within the geographic area served by the component Society or to a District Peer Review Committee as provided for hereinafter. The District Peer Review Committee shall function and operate on behalf of any component Society which does not establish such a committee.
- B. **Procedures**—The review committee of the component Society shall establish reasonable rules of procedure but shall not be bound by technical rules applied in courts of law or in administrative hearings conducted by governmental agencies. All complaints and inquiries shall be reduced to writing and shall be signed by the individual making the complaint or inquiry. Complaints received by the Illinois State Medical Society shall be referred to the proper component Society or District Committee.
- C. **Timely Reviews**—The review committee of the component Society shall consider all complaints and inquiries properly filed with the Society in a timely manner and shall render its advice within a reasonable period of time following the receipt of a properly submitted complaint or inquiry. In the event the component Society shall fail to act in a timely fashion, as required in its rules of procedure, the party submitting the complaint or inquiry may petition the Peer Review Appeals Committee of the Illinois State Medical Society, as provided for hereinafter, to take jurisdiction of the complaint or inquiry.
- D. **Appeals**—Such parties to the proceedings as delineated below, conducted by the component society may petition the Peer Review Appeals Committee of the Illinois State Medical Society to review certain local proceedings of the component society of district committee. A petition for



an appeal must set forth one of the following grounds as a basis for the appeal:

- 1. **PROCEDURAL ERROR**—The peer review proceeding was not conducted in accordance with written rules established by the component society, district committee, or the Illinois State Medical Society.
- 2. **BIAS**—The proceeding was conducted in a biased or arbitrary manner.
- 3. **INCOMPLETE INFORMATION**—If information not available to the component society or district committee is submitted to the State Peer Review Appeals Committee, the committee will first determine the relevancy of the new information. The case will be referred to the component society or district committee for reconsideration if the information is deemed to be pertinent and significant by the State Committee.

A member of the Illinois State Medical Society, who is a party to a peer review proceeding and who has received a final determination from the component Society, may file an appeal with the State Peer Review Appeals Committee, in accordance with Section D, as stated above, as a matter of right. A patient who brings a complaint shall enjoy the privilege of petitioning the State Committee to review the decision of a component Society and the State Committee shall, in its sole discretion, determine whether or not to accept the case on appeal. No other parties shall enjoy the privilege to appeal a decision of the component Society.

In the event of an appeal to the Illinois State Medical Society, the component Society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the findings and recommendations of the component Society or District Committee. The right to appeal to the Illinois State Medical Society Peer Review Appeals Committee shall be limited to 30 days after the decision of the component Society or District Committee, unless the appellant can provide an acceptable reason for additional time.

**Part 3. District Committee.** The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Peer Review Committee to function in those instances when the component Society chooses to delegate to its District Peer Review Committee the responsibility to perform the review functions set forth in this Chapter. Upon completion of hearings of each complaint or inquiry referred to it by the component Society, the District Committee shall render its findings and recommendations to the component Society for affirmation. The District Peer Review Committee shall also consider complaints or inquiries assigned to it by the Illinois State Medical Society Peer Review Appeals Committee in those instances when it is determined by the State Committee that a component Society has failed to act in a timely fashion on a peer review complaint or inquiry submitted to it.

**Part 4. Illinois State Medical Society Procedures.**

- A. There shall be created a Peer Review Appeals Committee, appointed by and reporting directly to the Board of Trustees. The Committee shall consist of seven members who shall serve one-year terms but, in no event, more than five consecutive one-year terms. Vacancies shall be filled by appointment by the Board.  
The Peer Review Appeals Committee shall review appeals of decisions of component or district peer review committees in accordance with the provisions of Part 2 (D) of this chapter. The state committee shall determine the validity of the alleged grounds and, if found valid, remand the case to the local or district committee for a rehearing. If the alleged grounds are found invalid, the decision of the district or county committee shall be deemed to be reaffirmed. The decision of the Peer Review Appeals Committee shall be forwarded first to the county or district committee and then to the appellant. The state committee shall have authority to assign cases to district peer review committees in accordance with Part 3 of this chapter. Decisions of the state committee shall be final.
- B. The State Peer Review Appeals Committee shall adopt appropriate rules for the conduct of its business and shall act on all appropriately filed appeals in a timely manner. The State Committee shall notify the appropriate component Society of its decision in a given case prior to its notification of the parties to the appeal.
- C. If, in the judgment of the State Committee, a matter submitted to it on appeal is deemed to be more appropriately treated as an ethical relations issue, the Committee shall refer that case for disposition to the Judicial Panel, created under Chapter XI of these Bylaws.

**CHAPTER XIII. MISCELLANEOUS**

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

**CHAPTER XIV. AMENDMENTS**

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

**CHAPTER XV. PARLIAMENTARY PROCEDURES**

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

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# 1982-1983

## Policy Manual

### of the

## Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, AMA delegates and alternate delegates, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

- (1) approve, amend, or reject—
- (2) refer the statement to the Board for reconsideration and subsequent report—

- (3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

Established policy must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.



## PROFESSIONAL POLICIES

### Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Abortions must be performed in conformance with state and federal law and current medical standards, and when so performed shall not be considered unethical. Physicians shall not be required to perform or participate in an abortion by hospital regulations or any other institutional requirement. (Amended, 1980 Annual Meeting)

### Abuse and Neglect of the Elderly

Physicians, nurses and other health care personnel are reminded to be aware of possible instances of abuse and neglect of the elderly and are encouraged to report suspected cases appropriately. (1982 Annual Meeting)

### Acupuncture

Acupuncture is a surgical procedure and its practice shall be limited to physicians licensed to practice medicine in all of its branches and to dentists. (1975 Annual Meeting—Reviewed by Board 1980)

### Advertising Guidelines, Physician Professional

In keeping with the Principles of Medical Ethics, as well as rules of law, the following advertising guidelines are adopted:

#### I. General

These guidelines shall apply to solo practitioners and groups of physicians, including medical clinics, HMOs, and other physician-operated facilities. The medical society recommends that these guidelines be suggested for hospitals and other health care institutions. The medical society does not look with favor upon advertisements which promote or produce unfair competition.

#### II. Acceptable Professional Identification

1. Name, with earned degree(s)
2. Office address and telephone
3. Home address and telephone
4. Answering service
5. Office hours
6. Medical specialization
7. Board certification
8. Type of practice (group, solo) and affiliation, so long as such identification is not misleading
9. Hospital affiliation
10. Foreign language competence
11. Usual and customary fees, for routine medical service. Such fee identification must include notification that fees may be adjusted in the event that complications or unforeseen circumstances arise. The usual and customary fee quoted shall be that fee charged to the majority of patients seeking the same basic service. Such fee identification must not be misleading. Average charges may not be stated.
12. Public announcement of changes in any of the above

#### III. Professionally Unacceptable

1. Testimonials or anecdotal reports of medical practice success

2. Claims of superior quality of care
3. Fee comparisons of available services with those of other licensed physicians or medical clinics
4. Listing of professional service which the offerer is not qualified to provide
5. Statements which contain false, fraudulent, deceptive or misleading material
6. Warranties or guarantees of success or unsuccessful therapy
7. Statements which play upon the fears and vanities of the public
8. Display or similar advertising that may serve to mislead or misinform the public
9. Solicitation of media coverage of medical services by means of "news stories" designed for personal or financial gain

#### IV. Media Guidelines

1. Newspapers and magazines
  - a. Type size shall be that text type used in the publication
  - b. Use of any ornaments, embellishments, or symbols is prohibited
2. Professional or business cards, and office signs giving allowable information are permissible
3. Health care services directories (including telephone directories) are subject to the same policies as stated under newspapers and magazines above

(1979 Annual Meeting)

### Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational or social adjustments as a direct consequence of persistent and excessive use of alcohol. Insurance companies should include appropriate coverage for alcoholism. Physicians and their hospitals are encouraged to actively participate in providing services for alcoholics. (Amended, 1980 Annual Meeting)

### Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that physicians and recognized community service agencies should enlarge their services to include treatment and counseling of alcoholics and their families, and, where appropriate, collaborate with recognized alcohol treatment programs; that education programs aimed at alcohol abusers who are drivers should be encouraged, and legal restrictions should be continued to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects, as well as socioeconomic impacts, should be encouraged. (Amended, 1980 Annual Meeting)

## Ambulance Services

All ambulance services should meet minimum standards as established by appropriate authorities in the field. ISMS should offer its expertise and work to ensure that ambulance services meet these standards.

(Amended, 1980 Annual Meeting)

## Anaphylactic Reactions to Insect Stings

ISMS favors development of mechanisms to allow the availability of epinephrine, through appropriately trained persons, upon the prescription of a physician.

(1981 Annual Meeting)

## Assessments

Medical staffs are reminded that hospitals do not have the privilege or the right to make compulsory assessments on individual members of the medical staff for building funds or other hospital programs, nor to demand an audit of staff members' personal financial records as a requisite for staff appointments.

(Amended, 1980 Annual Meeting)

## Athletic Programs

The medical profession should provide input into the structuring of athletic programs in an effort to minimize physical injuries and inappropriate emotional stress and to insure proper treatment.

(Amended, 1980 Interim Meeting)

## Audits and Surveys

ISMS recognizes the necessity of audits and surveys to review the appropriateness of medical services rendered. However, respect for personal privacy and confidentiality must be maintained with utmost priority under all circumstances. Additionally, local medical staff audits and determinations as to management must be respected. In this regard, ISMS recognizes audit processes as performed by organizations who have demonstrated compliance with the aforementioned principles. In contrast, audits and surveys not performed by recognized organizations, or those performed in violation of the above principles, will not be condoned.

(Amended, 1980 Interim Meeting)

## Autopsies

Because the autopsy has educational benefits for medical science as well as the family of the deceased individual, ISMS encourages its members to seek family approval for the post-mortem examination in all cases of death.

(1978 Interim Meeting)

## Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.

(Reviewed, 1980)

## Blood Availability

The Illinois State Medical Society encourages component societies to support abolition of blood bank replacement deposit fees (often referred to as penalty or non-replacement fees).

The Illinois State Medical Society and its component societies encourage hospitals and any other facilities to affiliate with a regional blood replacement center in their areas.

The Illinois State Medical Society and its component societies should assist appropriate organizations in establishing a regionally coordinated blood banking system throughout the state and areas contiguous to the state.

(1979 Annual Meeting)

## Blood Services

Inasmuch as blood services affect the entire community, the county medical society should be encouraged to become involved and should have input in blood bank activities serving its county.

(Amended, 1980 Interim Meeting)

## Cardiopulmonary Resuscitation

ISMS encourages basic cardiac life support training in Illinois high schools.

(1981 Annual Meeting)

## Child Abuse

ISMS urges all state health agencies and family service agencies which become involved in child abuse cases, to conduct, promptly, necessary investigation of the family environment prior to the release of the child for return to the same home where the abuse occurred.

(1981 Interim Meeting)

## Child Safety Restraints

ISMS supports and encourages public education and legislation promoting child safety restraint use (infant and toddler car seats) and encourages physicians and others to discuss their benefits with all parents. Physicians are encouraged to learn about important safety features which have proven effective.

(1981 Interim Meeting)

## Code of Ethics

The following Code of Ethics represents standards of conduct defining the essentials of honorable behavior for the physician. They are not laws.

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.



5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
  6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.
  7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.
- (1981 Interim Meeting)

## Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileged communication must be continued in accomplishment of the treatment of human illness. Section IV of the Principles of Medical Ethics states that: "A physician shall respect the rights of patients . . . and shall safeguard patient confidences within the constraints of the law." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept of confidentiality of the doctor-patient relationship as it relates to the ambulatory patient record and will take an active role in uncovering any violation of the doctor-patient relationship by officials and personnel of review organizations and will take whatever steps are necessary to eliminate the breach of confidence.

ISMS is in opposition to the use of the Social Security number as a universal number identifier.  
(Reviewed, 1981)

## Continuing Education

Continuing education is one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multi-faceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

ISMS will act as an accrediting agency under the policies of the Accreditation Council for Continuing Medical Education as established by the organizations comprising the Council for Medical Affairs. The Illinois State Medical Society should have the primary role in accrediting of quality continuing medical education programs in order to assure that members have access to CME opportunities which are in conformance with licensing regulations of the State of Illinois.

Physicians are encouraged to analyze their individual learning needs before registering for CME courses.

Financial support for the Illinois Council on Continuing Medical Education is provided by the Board of Trustees of ISMS. ICCME shall prepare an annual financial report for the House of Delegates indicating (a) major sources of income, (b) major categories of expenditure and (c) a proposed budget for the year in which the House is meeting.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

Sponsors of continuing medical education courses should

provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses. Accrediting body and category of credit should be stated.  
(Amended, 1981 Annual Meeting)

## Cost Containment

ISMS endorses the Voluntary Effort of American physicians and hospitals as responsible private sector activity to restrain hospital costs without arbitrary limits or governmental intervention, and it endorses the AMA president's call for physicians to help moderate care costs.

ISMS supports the concept of voluntary planning. ISMS should continue monitoring of planning legislation as to costs, benefits, and effectiveness; and encourage establishment of equitable techniques for administration of federal requirements. ISMS opposes imposition of the public utility type of regulation of the medical profession, whether institutional providers or private physicians. Certificate of need, as a cost containment mechanism, is a non-proven concept and requires continued evaluation.

"Decertification" or conversion to other use of excessive facilities should be on a voluntary and trial basis before final implementation.

The development of appropriate policies and mechanisms that lead to continuity, coordination, and continuous availability of patient care, including appropriate professional preventive care and appropriate early-detection screening services should be encouraged. The appropriateness of a service, test or treatment should be the primary factor in considering its necessity rather than the cost.

Regulatory systems to certify and monitor the performance of insurance carriers, mutual insurance companies and other organizations financing health care services should be established to assure fiscal responsibility and accurate representation of premium or capitation costs and benefits that will not restrict development of innovative approaches to benefit coverage.

(1978 Interim Meeting)

## Current Procedural Terminology

The Illinois State Medical Society endorses the American Medical Association's Current Procedural Terminology and encourages its use by Illinois physicians.  
(1977 Annual Meeting)

## Death, Legal Definition of

A determination of death is a medical diagnosis which must be made in accordance with accepted medical standards by a physician licensed to practice medicine in all its branches, which may be made when an individual has sustained either: (1) Irreversible cessation of circulatory and respiratory functions, or (2) Irreversible cessation of all functions of the entire brain, including the brain stem.

(Amended, 1981 Interim Meeting)

## Death With Dignity

The Illinois State Medical Society will continue to oppose death with dignity, right-to-die and similar legislation, based upon what must necessarily be a private matter between physician and patient. If passage of such legislation is imminent, it must provide immunity from civil and criminal penalties for physicians who act in good faith and in accordance with accepted medical practice and must not require physicians

to act in violation of their own personal beliefs, morals and conscience.  
(Amended, 1981 Annual Meeting)

## Disaster Control

All medical societies should cooperate with and contribute to disaster plans in their communities.  
(Amended, 1980 Annual Meeting)

## Drugs, Prescriptions

Prescription drugs may be dispensed only upon the authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Only those generic drugs which are actually bio-equivalent should be included in the Illinois Formulary for the Drug Product Selection Program of the Illinois Department of Public Health.

ISMS urges IDPH to monitor and enforce proper generic drug substitution by pharmacists according to bio-equivalency based on the formulary.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.

(Amended, 1982 Annual Meeting)

## Drunk Drivers

ISMS supports law providing for stiffer sentencing of drunk drivers and encourages the judiciary to recommend rehabilitative treatment as an additional means of dealing with people convicted of driving while under the influence of alcohol.  
(1981 Interim Meeting)

## Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.  
(1976 Annual Meeting—Reviewed by Board 1981)

## Emergency Medical Care, Provision of

Emergency care should be provided regardless of the ability of the patient to pay. Physicians should be aware of the protection afforded them by the Good Samaritan provisions of the Illinois Medical Practice Act.

Insurance plans which cover emergency medical services should pay for such services regardless of where they are rendered.

(Amended, 1981 Annual Meeting)

## Ethics

It is ethical for physicians to associate professionally with whom they wish, acknowledging always that there is no compromise on the historically noble goals of honesty, competence, compassion, respect for dignity, furtherance of knowledge,

safeguarding of confidence and service to mankind, and with due regard to modern medical science.  
(1979 Interim Meeting)

## Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.  
(1966 Annual Meeting—Reviewed by Board 1980)

## Experimental Medical Procedures

With respect to experimental medical procedures, physicians must adhere to and affirm the following:

Accepted ethical standards;

The codified regulations of the Department of Health and Human Services as specified in Title 45 USC, Sec. 46;

Appropriate Illinois statutory or regulatory requirements.  
(Amended, 1981 Annual Meeting)

## Eyes

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or use eye medications; only such physicians should continue to be the primary entry-point for eye care. ISMS vigorously opposes any attempt in Illinois to give optometrists a license to prescribe or use medications or to serve as a primary entry-point in the provision of eye care.

(1976 Annual Meeting—Reviewed by Board 1980)

## 55 M.P.H. Speed Limit

The Illinois State Medical Society opposes an increase in the 55 mile per hour speed limit.  
(1981 Annual Meeting)

## Firearms

The Illinois State Medical Society supports the right of counties or municipalities to enact ordinances restricting the ownership, possession, purchase, sale, transport or transfer of firearms or firearm ammunition. It opposes any state legislation in Illinois that would prohibit the enactment or enforcement of county or municipal ordinances restricting the ownership, purchase, sale, transport or transfer of firearms or firearm ammunition.

(1982 Annual Meeting)

## Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost.

The Illinois Foundation for Medical Care is completely accountable only to the House of Delegates, through the Board of Trustees of ISMS, and to each component society of ISMS.

Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored



programs can be developed and administered throughout the state.

The Illinois Foundation for Medical Care is authorized to investigate and, if economically feasible, to implement programs for supporting physician organizations endorsed by constituent medical societies. Such support is to be in the areas of data needs and other specialized activities, such as statewide co-ordination, statistical analysis, co-ordinated negotiations and support of related state level organizations, utilizing public, governmental or private funds to reimburse the foundation for such activities. Specifically, the IFMC Board is authorized to investigate the feasibility of becoming a statewide support center for physician organizations endorsed by constituent medical societies and to provide administrative support, data processing and specialized services to such physician organizations.

(1977 Interim Meeting)

## Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

ISMS supports the concept of second opinion—only via the usual and customary referral pathways guaranteeing the free choice of physicians.

(1976 Interim Meeting—Reviewed by Board 1981)

## Governmentally Supported Health Facilities

ISMS should not facilitate the development of governmentally-supported Health Maintenance Organizations or similar practice alternatives which would be discriminatory against the private or group practice of medicine.

(1978 Annual Meeting)

## Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs and encourages physicians to receive and review the hospital bill of each patient he hospitalizes as a voluntary step toward cost containment of health care.

ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees and reaffirms its faith in the private enterprise system which has made the United States great and strong and which seeks to make health care available to everybody.

The Illinois State Medical Society encourages cost sharing by patients in all medical care reimbursement plans.

(1977 Interim Meeting)

## Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields

shall be provided with all pertinent information.  
(1967 Annual Meeting—Reviewed by Board 1980)

## Health Insurance, Governmental Programs

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which quality of care is compromised.

It is opposed to national compulsory catastrophic health insurance.

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs of psychologists, social workers or any group of individual practitioners without medical supervision.

(Amended, 1979 Interim Meeting)

## Health Insurance, Voluntary Plans

ISMS supports private, voluntary, catastrophic health insurance, including freedom of choice of physician. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

The Illinois State Medical Society supports the concept of increased insurance coverage for ambulatory diagnostic tests.

It supports the policy of a tax credit or deduction for the premium expense of catastrophic medical insurance and endorses the principle that, under federal rules and regulations, the costs and premiums for health care, whether incurred directly by an individual or conferred as an employee benefit, should be equally deductible.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

When insurance benefits are assigned to a physician by a patient, care should be exercised by the insurance company, or its agent, in seeing that such wishes of a patient are followed. If an error is made by the insurance company, or its agent, and payment is made to the patient, the insurance company is urged to admit its error and pay the physician as it was originally directed to do. Under such circumstances, recouping of the money from the patient should be the responsibility of the insurance company, or its agent, that committed the error and not the responsibility of the physician.

ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by:

- Imposing on patients that physician's charges above insurance benefit allowances are excessive;

- Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;

- Suggesting that physicians perform alternative surgical procedures;

- Instituting utilization review of hospital patients in the private sector which by-passes local physician review mechanisms;

- Discriminating against the physician who does not

have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician.

ISMS endorses long-held principles that:

A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); and

The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician).

(Amended, 1982 Annual Meeting)

## Health Planning

ISMS supports health planning on a local and voluntary basis with input by a significant number of physicians licensed to practice medicine in all its branches. Planning and implementation of the plan (regulation) are two different processes and should be kept separate and distinct.

(Amended, 1982 Annual Meeting)

## Health Screening by Allied Health Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.

(1974 Annual Meeting—Reviewed by Board 1980)

## Health Systems Agencies

The Illinois State Medical Society supports legislative activity by the American Medical Association repealing the Federal Health Planning Act, Public Law 93-641 and Public Law 96-79 as amended. As an interim measure, ISMS will seek legislative amendment in Congress or an administrative exemption removing those portions of the Health Planning Act which impose penalties on states not in compliance with federal SHPDA designated criteria.

(1981 Annual Meeting)

## HSA Fund Solicitation

The Illinois State Medical Society is opposed to outside fund solicitation by Health Systems Agencies; for such practices may affect the objectivity of the organization.

(1980 Annual Meeting)

## Hearing Disorders

Physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment.

(1977 Annual Meeting)

## Hospices

A hospice is a centrally administered program of palliative and supportive services providing medical, social, psychological and spiritual care for terminally ill persons and their families. Services are provided by a medically-supervised, interdisciplinary team of professionals and volunteers. Care is offered 24 hours a day, 7 days a week, through either in-patient settings, home care or a combination of both. Bereavement counseling is provided for the survivors.

(1981 Annual Meeting)

## Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

All county medical societies are encouraged to form standing committees composed of medical society officers and representative officers of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations, governmental and quasi-governmental agencies in their community.

The Illinois State Medical Society encourages the development of local peer review plans for appropriate review of utilization of hospital emergency rooms.

(1977 Annual Meeting)

## Hospital—Medical Staff—Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on a medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of a hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

Results of recertification examinations should not be the sole criterion used by hospital governing bodies and hospital medical staffs in the granting of clinical privileges.

(1978 Annual Meeting)

## Hospital Medical Staff Privileges

Members of a medical staff should receive due process as spelled out by the Bylaws of the medical staff before their medical staff privileges can be terminated. The Illinois State Medical Society supports physicians in their right to continue to practice in a community or hospital as long as they follow the bylaws of the medical staff and maintain the highest quality of medical practice to their patients unless good cause can be shown that continuation of the physician in practice is not in the best interest of his/her patients.

(1980 Annual Meeting)

## IDPA Drug Manual

ISMS approves the concept that pharmaceutical products for inclusion in the IDPA Drug Manual be based on therapeutic effectiveness rather than cost. While ISMS members will con-



tinue to be cost conscious in all aspects of medical care, this care must be based upon therapeutic considerations and bio-equivalence.  
(1981 Annual Meeting)

## Immunization Programs

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection or to encourage the local public health agency to perform this function, and to encourage enforcement of current immunization laws. In addition, physicians should be encouraged to participate in epidemiological studies (especially as related to "search and destroy" methods for communicable diseases) which have been endorsed by the local or state medical society.

Every school district should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.  
(Amended, 1981 Annual Meeting)

## Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.  
(Prior to 1965—Reviewed by Board 1980)

## Informed Consent

ISMS endorses the position that disclosures made to patients conform to the general practices of the medical profession in the same or a similar community or locality, which are disclosures that a reasonable medical practitioner would make under the same or similar circumstances.

ISMS opposes legislative definition of informed consent.  
(1982 Annual Meeting)

## Laboratories

All laboratories providing medical data should be under the direct supervision of a physician currently licensed to practice medicine in all its branches.  
(Amended, 1980 Interim Meeting)

## Manipulative Casting of Congenital Deformities of the Extremities

Manipulative casting of congenital deformities of the extremities, whether performed in the office or hospital, is considered a surgical procedure.  
(1981 Annual Meeting)

## Marijuana

ISMS does not endorse the legalization of the possession or use of marijuana.

Since the medical and psychiatric knowledge concerning the short-term and long-term effects of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.  
(1976 Annual Meeting—Reviewed by Board 1980)

## Medical Diagnosis and Treatment

While the Illinois State Medical Society recognizes the interests of third parties in patient care, it categorically maintains that prognosis and length of treatment must always be individualized to the patient, the diagnosis, and community standards for medical care.  
(Amended, 1980 Annual Meeting)

## Medical Education—Schools

The Illinois State Medical Society supports development of innovative programs in medical education maintaining a firm foundation in the basic sciences.

It favors admission of students into medical schools on the basis of their ability to be good medical students and physicians.

Graduates of state medical schools are encouraged to practice medicine in Illinois and ISMS will utilize its organizational structure to develop positive incentives.

ISMS encourages primary care residency programs to establish educational activities in the rural and underserved areas of Illinois.  
(Amended, 1982 Annual Meeting)

## Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coronor system, wherever practical.  
(1971 Annual Meeting—Reviewed by Board 1980)

## Medical Liability Insurance Premiums

The Illinois State Medical Society supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category.  
(1979 Annual Meeting)

## Medical Psychotherapy

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves

verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches.

(Amended, 1980 Annual Meeting)

## Medical Representation in Government Planning

Unless physicians appointed to the boards and committees of other organizations are nominated by their local county medical society, such physicians shall not be considered "representative" of the medical community.

(Amended, 1978 Interim Meeting)

## Medical Testimony, Expert Witnesses

An expert medical witness is defined as a physician licensed to practice medicine in all its branches having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, current personal experience, practical familiarity, and technical knowledge of the problems that are being considered, as well as alternative forms of treatment, and is currently active in the practice of the medical subject under discussion.

Any physician licensed to practice medicine in all its branches who functions as an expert witness, must satisfy the definition of an expert witness that the definition be a matter of policy, and that it be considered unethical conduct on the part of any physician appearing as an expert witness who does not meet this standard.

(1977 Annual Meeting, Reviewed, 1981)

## Medical Testimony, Impartial

The ends of justice are served when impartial medical witnesses are available to the judiciary. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

(Amended, 1980 Annual Meeting)

## Medicare Assignments

The Illinois State Medical Society supports the concept that Medicare payments be made directly to physicians who choose to accept Medicare assignments. When a Medicare payment is incorrectly made directly to the patient, Medicare should make full payment to the physician who has chosen to accept Medicare assignments as soon as the error is verified.

(1980 Interim Meeting)

## Mental Health

The Illinois State Medical Society strongly opposes a double standard of care in state hospitals.

The Department of Mental Health and Developmental Disabilities (DMHDD) should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating state funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians.

Each constituent county society should cooperate fully with and support local units of the DMHDD in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, *i.e.*, crisis intervention, to be available areawide.

All physician or other health service provided to the DMHDD, other than that by fulltime employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

Involuntary psychiatric hospital certification, initial or subsequent, must without exception remain the responsibility of a physician licensed to practice medicine in all of its branches and a physician licensed to practice medicine in all of its branches should be required to certify the discharge of any patient from a psychiatric institution.

(1977 Annual Meeting, Reviewed by Board, 1981)

## Motorcycle Helmets

All Illinois physicians should encourage their patients who use motorcycles to wear protective helmets, pointing out the efficacy of such helmets in preventing death during collisions.

(1982 Annual Meeting)

## Multiphasic Screening

Multiphasic screening tests (including brief physical examination and multiple automated laboratory tests) are accepted procedures for health evaluation when carried out in a scientific manner and in conformance with laws of the State of Illinois and regulations of the Department of Public Health. The persons participating in or sponsoring these activities should be advised that: (1) Abnormal findings do not necessarily indicate a disease exists; such a determination must be made by a physician; (2) The absence of abnormal findings does not necessarily indicate the patient is free of disease; and (3) That such screenings should be done under the guidance of local medical societies or other recognized medical authorities.

(Amended, 1980 Interim Meeting)

## Nurses-Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

(1970 Annual Meeting—Reviewed by Board 1980)

## Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.

(1973 Annual Meeting—Reviewed by Board 1980)



## Nutrition

Proper attention to patients' complete nutritional status should be of concern to all physicians. Patient education in the field of nutrition should be a major priority.  
(Amended, 1980 Annual Meeting)

## Occupational Health

Occupational health is an essential ingredient of employee welfare. The continued adoption and development of occupational health programs in the private and public sectors should be encouraged.  
(Amended, 1980 Interim Meeting)

## Optometric Services

ISMS supports the concept that those performing optometric services in Veterans Administration facilities should be directly responsible to their respective departments of ophthalmology.  
(1978 Annual Meeting)

## Patient Care Records and Their Availability

Patient care records contain privileged information of confidential nature. Such records are the property of the hospital, clinic or physician. Information contained therein is held in trust by the holder.

In the case of hospital records, patients, patients' attorneys or patients' succeeding physician, upon written patient authorization, have the right of access to hospital records, the ability to review and the right to copy or receive copies. Hospitalized patients may be afforded access to their records upon discharge but not during hospitalization. This access is not afforded in case of psychiatric illness. In the case of non-hospital records, patients' attorney or succeeding physician, but not patients themselves, upon presentation of written patient authorization, have the right of access to said records, with the ability to review and the right to copy and receive copies.

Upon receipt of proper, written authorization from the patient, a copy abstract or summary shall be provided, as required, to legally authorized recipients of such record.

Patient records are utilized by official committees of organized medical staffs to accomplish scientific review, peer review or other patient care improvement. Reports and proceedings of such committees are confidential and shall not be disclosed to any person outside the purview of such committees.

Pursuant to a subpoena for records, a physician is legally required to release medical records in the absence of a signed patient authorization. It is recommended that when records are released, a copy be maintained in the physician's file.

A reasonable charge for record copying service may be made. Reference may be made 1979, Illinois Revised Statutes, Chapter 48, Section 138.8; Chapter 51, Section 71, 73 and 101; Chapter 91½, Section 800ff.  
(Amended, 1981 Annual Meeting)

## Peer Review

Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues.

Peer review shall be conducted by a local medical society, or its designee, at the local level whenever possible. Major

ethical relations questions identified during deliberation of the Peer Review Committee shall be appropriately referred.

ISMS supports physician assessment of the quality of medical care and urges physicians to maintain control and direction over peer review, regardless of what mechanisms evolve for peer review, and over public or private funds that are directed to such activities.

### *Utilization Review*

ISMS encourages hospital medical staffs to perform focused utilization review of all patients in selected diagnostic categories, regardless of the source of payment, and urges all third party payors—private carriers as well as government—to provide reimbursement to hospitals and physicians for time and expense incurred in focused utilization review.

ISMS further urges the Illinois Department of Public Aid to continue to use existing physician peer review organizations, and will vigorously oppose the use by IDPA of any alternative peer review structure.  
(Amended, 1981 Interim Meeting)

## Physician Records, Privacy of

The Illinois State Medical Society will take whatever action is necessary to assure that no third party be granted access to the physician's own private medical practice business records, including copies of cancelled checks, cash disbursement journal, leases, contracts, or other confidential business records, without appropriate authority assuring due process.  
(1978 Interim Meeting)

## Physicians

The term, "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches."  
(Amended, 1981 Interim Meeting)

## Physician's Assistants

The Illinois State Medical Society recognizes the physician's assistant as a trained health professional who can serve a proper function within the scope of his/her certification and under the direct one-to-one supervision of a physician.  
(1980 Annual Meeting)

## Prolonging Human Life

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.

(1976 Annual Meeting)

## Psychosurgery

Psychosurgery refers to those surgical operations which irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.

(1975 Annual Meeting—Reviewed by Board 1980)

## Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by state/federal programs to physicians should be based upon the usual and customary fee concept.

Because modern medical care frequently requires multi-specialty medical management, including primary care physicians and specialists working together for the benefit of the patient, traditional fees for multi-specialty care for Public Aid patients should be made available without extensive justification procedures.

(Amended, 1981 Interim Meeting)

## Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and, if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

ISMS encourages and supports the development of local joint committees of county medical societies and county public health departments to review current and proposed public health projects.

ISMS encourages local health departments and component medical societies to delineate the roles of the public and private sectors in providing health and medical services to the community. The following should be considered: 1) coordination and facilitation of direct services which should occur in a manner to avoid duplication of available medical services; 2) the availability of private medical services; 3) the gaps in medical and health services that should be filled by public health activities; and 4) the socio-economic characteristics of the population to be served.

(Amended, 1980 Annual Meeting)

## Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

(Prior to 1965—Reviewed by Board 1980)

## Reimbursement of Ambulatory Services

Third party payors should be encouraged to provide coverage for ambulatory surgery and diagnostic procedures. Final medical decisions must remain in the hands of the attending

physician. However, the Illinois State Medical Society supports the concept of maximum utilization of ambulatory surgical services consistent with the doctor's judgment of the facilities available.

(Amended, 1982 Annual Meeting)

## Reimbursement for Medical Care of Psychiatric Illness

Medical care of psychiatric illness should be included in all health insurance policies.

(1980 Annual Meeting)

## Reimbursement for Out-Patient Services

Third-party payors should be encouraged to provide coverage for outpatient diagnostic tests and surgery.

(1980 Annual Meeting)

## Reimbursement for Treating Medicaid Patients

The Illinois State Medical Society approves in principle the concept of amending appropriate state and federal laws to provide physicians with the option of taking state and federal income tax credits or deductions in lieu of direct reimbursement for the treatment of Public Aid recipients.

(1981 Annual Meeting)

## Relationship with Third-Party Payors

ISMS should provide guidance, education, communications, and negotiations between the membership and third-party payors.

(1980 Annual Meeting)

## Smoking

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and will encourage medical staff action to make hospitals tobacco smoke-free.

Physicians and their employees should refrain from smoking during patient contacts.

Physicians should give advice and provide literature and signs concerning the health hazards of smoking.

ISMS encourages and supports efforts, legislative and otherwise, to ban or restrict smoking in all public places and the development of appropriate regulations to accomplish this.

(Amended, 1979 Interim Meeting)

## Surgery, Reconstructive

Surgery to correct post-surgical deformities is reconstructive surgery.

(1979 Annual Meeting)

## Surgery, Second Opinion for

Recognizing that the advisability of surgery or other special therapy can be a matter of opinion, the Illinois State Medical Society (1) reaffirms the right of the patient to seek a second opinion freely from any physician of his/her choice; (2) opposes the concept of mandatory second opinions or the imposition



of financial penalties by a third-party payor for not obtaining a second opinion; and (3) supports the concept that, when a second opinion is required by a third-party payor, that second opinion should be at no cost to the patient.  
(1979 Annual Meeting)

### **Third Party Intrusion Into Medical Judgment**

Medical judgment and decision-making power of the treating physician must not be abrogated by third party payors. ISMS is opposed to any third party having the power of decision as to medical necessity of services and supplies, including hospitalization, over and above the judgment of the treating physician.  
(1978 Annual Meeting)

### **Tobacco Farm Subsidies**

The Illinois State Medical Society opposes the subsidization or price supports of tobacco farming.  
(1982 Annual Meeting)

### **Usual and Customary or Reasonable Reimbursement**

The Illinois State Medical Society endorses the AMA policy on physician reimbursement, which supports only the usual and customary or reasonable concept, rather than any type of negotiated fee schedule.  
(1979 Annual Meeting)

### **Veterans Administration**

The Illinois State Medical Society continues to support the concept that a Veterans Administration hospital should only be concerned with the needs of those patients with service-connected disabilities.  
(Amended, 1980 Annual Meeting)

### **Violence**

The Illinois State Medical Society opposes the ready accessibility to hand guns without evidence of responsibility on the part of the possessor and urges strict enforcement of present federal, state and city laws and that the courts, as well as the legislature, impose maximum penalties on all offenders.

The Illinois State Medical Society will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians, including the offering of rewards and other incentives in the solution of such cases.  
(1978 Annual Meeting)

### **Workers Compensation**

The Illinois State Medical Society advocates a single radiologic examination to satisfy the medical requirements at a given time in the course of a workers compensation injury.  
(1982 Annual Meeting)

## **ADMINISTRATIVE POLICIES**

### **AMA-ERF**

The AMA-ERF contributions for Illinois graduates shall be distributed to the Illinois medical school from which the member graduated.

The contribution for the balance of the membership shall be distributed to Illinois medical schools in the same proportion as above.

Any member may over-ride this procedure and designate a school of choice by advising ISMS in writing.  
(Amended, 1980 Interim Meeting)

### **Autonomy of County Medical Societies**

In all areas, the county medical society shall be autonomous. Actions of any county medical society should conform with the Constitution and Bylaws of the Illinois State Medical Society.  
(Amended, 1980 Interim Meeting)

### **Budgets—(see "Financial Policies")**

### **Committee Appointments**

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Individual tenure on any committee should be limited to a maximum of five years of continuous membership.

Physicians appointed to Illinois State Medical Society committees must be members in good standing of this Society.  
(1978 Interim Meeting)

### **Councils and Committees**

It is the policy of the Board of Trustees to encourage evening

or weekend meetings of councils and committees at convenient locations to improve membership involvement in council and committee activities.  
(1981 Annual Meeting)

## Disciplinary Action

The Illinois State Medical Society will immediately communicate any disciplinary action by the Department of Registration and Education to the appropriate county society.  
(1980 Interim Meeting)

## Dues Approval Procedure

All financial matters involving changes in dues, dues structure, allocation of dues, or levying of assessments in any such manner shall be distributed to all delegates and alternate delegates and to all presidents and secretaries of county medical societies at least thirty days prior to the convening of the House of Delegates  
(1980 Annual Meeting)

## Election of AMA Delegates

Delegates to the American Medical Association should be elected from those having served first as alternate delegates.  
(Amended, 1980 Annual Meeting)

## Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) ISMS funds used by members campaigning for elections as AMA officers, trustees or members of councils or committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

(4) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(5) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(6) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(7) In addition to fixed reserves, the development of a contingency reserve is desirable.

(8) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.  
(1977 Annual Meeting)

## Honoraria For Officers

The Finance Committee is instructed to evaluate annually the honoraria paid to ISMS officers and to recommend appropriate changes to the Board of Trustees for consideration and action, reporting any changes to the House of Delegates at its next session.  
(1978 Annual Meeting)

proper changes to the Board of Trustees for consideration and action, reporting any changes to the House of Delegates at its next session.  
(1978 Annual Meeting)

## Illinois Medical Journal

The Publications Committee, with approval of the Board of Trustees, has authority to carry out publication policy. The committee is responsible for screening proposed advertising copy and advertisers, as well as for direction of the editorial content.

ISMS asserts the right to first refusal of original papers presented at programs for which ISMS is primary fiscal sponsor.  
(1981 Annual Meeting)

## Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with the Society's basic philosophy.  
(Prior to 1965—Reviewed by Board 1980)

## Informing the Membership

The membership of the Illinois State Medical Society shall have been properly informed when the following items have been accomplished:

1. Official notice in the *Illinois Medical Journal*;
2. Brief notice in Action Report, outlining the issue and calling attention to the *IMJ* article; and
3. A letter is sent to all county society presidents, secretaries and county executives.

(1977 Annual Meeting)

## ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.  
(Prior to 1965—Reviewed by Board 1980)

## ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils or major committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except when emergency action is necessary because of unexpected vacancies.

Nomination for appointments to subcommittees, ad hoc committees, other minor committees of AMA or as AMA representatives to certain outside agencies may be made directly by the Chairman of the ISMS Board of Trustees, after consultation with the Chairman of the ISMS Delegation, without specific approval of the full Board of Trustees or AMA Delegation. Such action shall be reported to the Board of Trustees and the AMA Delegation.



Upon receiving notice that an Illinois physician has been nominated for AMA position by an organization other than ISMS, the Chairman of the ISMS Board of Trustees, pursuant to the recommendation of the Chairman of the AMA Delegation, shall inform AMA only whether or not the nominee is a member in good standing of ISMS.  
(Amended 1981 Interim Meeting)

## Legal Counsel

The legal counsel of the Illinois State Medical Society shall serve the Society at the direction of the Board of Trustees. Counsel shall respond to official inquiries from officers, trustees, committee chairman and county medical societies. Such inquiries shall be channeled through the Board of Trustees.  
(Amended, 1980 Annual Meeting)

## Legislation

All matters presented to the House of Delegates or Board of Trustees pertaining to state or federal legislation shall be reviewed by the Governmental Affairs Council, which shall evaluate its potential impact on the society's current legislative efforts. The council shall submit its report to the Board of Trustees, which shall advise and recommend action to the House through the Chairman of the Board.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Governmental Affairs Council of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any council or committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House committees in support of, or in opposition to, the legislation recommended by the council or committee.  
(Amended, 1981 Interim Meeting)

## Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physicians' judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.  
(1974 Annual Meeting—Reviewed by Board 1980)

## Mailing List

The use of the mailing list of ISMS members must be approved by the Board of Trustees.  
(Amended, 1980 Annual Meeting)

## Medical Representation in Government Planning

In health programs financed by government funding in an

Illinois community, there shall be representation at the highest policy level by an official representative of the state society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Only physicians appointed to the boards and committees of other organizations who are endorsed by their local county medical society shall be considered "representative" of the medical community.  
(1978 Interim Meeting)

## Participation in Service Organizations

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

(Amended, 1980 Interim Meeting)

## Physician Recruitment Service

The Illinois State Medical Society shall coordinate activities connected with recruiting doctors to practice in Illinois. It shall maintain a Physician Recruitment Service to disseminate information about physician-short communities to doctors who have indicated to the service that they wish to relocate in Illinois. It shall take an active role with other organizations in Illinois conducting recruitment activities.  
(1980 Annual Meeting)

## Polls, Opinion

The Board of Trustees is responsible for ascertaining the opinion of members on critical issues facing the society. Periodic membership opinion polls should be considered as one means of ascertaining member opinion. However, the vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership since delegates are the duly elected representatives of their county medical societies and it is the responsibility of the delegates to determine the thinking of their constituents so that their voting will express this opinion. The majority opinion is expressed in the House of Delegates and it should be unnecessary to conduct a membership poll except under very exceptional conditions.

(1976 Interim Meeting, Reviewed by Board, 1982)

## Press

In order to provide the public with prompt and accurate information on all health-related matters, all county medical societies are encouraged to cooperate with the local news media.

County medical societies are responsible for providing their local media with information concerning official county society statements or actions, and should serve as a source of information on health issues of local concern.

The state society is solely responsible for disseminating information on its official actions, statements or views of the Illinois State Medical Society on issues with statewide or national implications.

(Amended, 1980 Interim Meeting)

## Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians, including the right of individual physicians to appear before appropriate peer review committees responsible for this liability coverage.  
(Amended, 1978 Interim Meeting)

## Public Statements

Only officially designated persons may publicly speak for the society. The chairman of the Board of Trustees, at the request of the President, shall designate ISMS spokesmen.

Spokesmen should bear in mind that, as representatives of the society, they should refrain from expressing their personal views. Their public statements should be—to the best of their ability—in consonance with the society's policies and positions.  
(1978 Annual Meeting)

## Public Statements, Endorsements

No officer, member of the Board of Trustees, council or committee chairman or staff member is permitted (during his term of office or employment) to allow his name and ISMS title to be used in lists endorsing candidates for public office. No one shall use the official Illinois State Medical Society stationery for personal statements of any nature, including the endorsement of any candidate for public office.  
(1980 Annual Meeting)

## Reference Service

County medical societies should establish procedures for referral of patients seeking physician services. It is appropriate to announce the availability of such an activity via the news media as a public service. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.  
(Amended, 1980 Interim Meeting)

## Resident Participation at County Level

The Governing Council of the ISMS Resident Physicians

Section will serve in an advisory role for component societies planning resident participation at the local level.  
(1980 Annual Meeting)

## Resident-Student Alternate Delegates to AMA

The Resident Physicians Section and the Medical Student Section shall recommend to the chairman and the secretary of the AMA Delegation the names of residents and students to be appointed to fill any alternate delegate vacancy on a temporary basis.  
(1979 Annual Meeting)

## Resolutions

Since the relationship between the Illinois State Medical Society and other voluntary physician membership organizations is the responsibility of the Board of Trustees, the Speaker of the House of Delegates shall refer to the Board any resolutions making reference to other voluntary physician membership organizations not affiliated with ISMS.  
(1976 Interim Meeting)

## Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable.

Specialty societies represented on the Council on Affiliate Societies shall be invited to submit recommendations for appointment to ISMS councils. Persons so recommended shall be members of both ISMS and the specialty society making the recommendation.  
(1979 Annual Meeting)

## Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.  
(1974 Annual Meeting—Reviewed by Board 1980)

# Policy Manual Appendix

## Statement of Understanding

*(between patient and physician)*

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government, or the like). Neither my doctor

nor I will permit any third party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.



## TRUSTEE DISTRICT COMMITTEES

### First District

John J. Ring, Mundelein, *Trustee*  
Counties of Kane, Lake, McHenry

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
David Clark, Aurora, <i>Chairman</i> .....	1984
Emanuel Herzon, Elgin .....	1984
Gerald Liesen, St. Charles .....	1985
A. M. Rosetti, McHenry .....	1983

#### PEER REVIEW COMMITTEE

David Helberg, Waukegan, <i>Chairman</i> .....	1984
Eugene Pitts, Waukegan .....	1984
James Pritchard, Geneva .....	1984
Peter Vinceguerra, Libertyville .....	1984

### Second District

Allan L. Goslin, Streator, *Trustee*  
Counties of Bureau, LaSalle, Livingston, Marshall, Putnam,  
Woodford

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
William Erkonen, Streator, <i>Chairman</i> .....	1983
Julius Kowalski, Princeton .....	1983
Karl T. Deterding, Pontiac .....	1983
Merle Swearingen, Lacon .....	1983

#### PEER REVIEW COMMITTEE

Louis Tarsinos, Princeton, <i>Chairman</i> .....	1985
James B. Aplington, LaSalle .....	1985
Silvio Davito, Spring Valley .....	1985
Bernard J. Doyle, LaSalle .....	1985
William Ehling, Streator .....	1983
Theodore W. Wagenknecht, Streator .....	1985
Robert Betasso, Ottawa .....	1985

### Third District

Richard Blankshain, Oak Park, *Trustee*  
Alfred Clementi, Arlington Heights, *Trustee*  
Audley F. Connor, Jr., Chicago, *Trustee*  
Morris T. Friedell, Chicago, *Trustee*  
Robert C. Hamilton, Chicago, *Trustee*  
Henrietta Herbolsheimer, Chicago, *Trustee*  
Lawrence L. Hirsch, Chicago, *Trustee*  
Harold J. Lasky, Chicago, *Trustee*  
Richard N. Rovner, Chicago, *Trustee*  
Joseph C. Sherrick, Chicago, *Trustee*

### Fourth District

George Burke, Rock Island, *Trustee*  
Counties of Fulton, Hancock, Henderson, Henry, Knox,  
McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark,  
Tazewell, Warren

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Richard Icenogle, Roseville, <i>Chairman</i> .....	1983
Earl Clark, Rock Island .....	1984
Jerry Ramunis, Victoria .....	1985

#### PEER REVIEW COMMITTEE

Donald Dexter, Macomb, <i>Chairman</i> .....	1983
William Daugherty, Moline .....	1984
G. W. Giebelhausen, Peoria .....	1984
James C. Parsons, Geneseo .....	1985
Clarence Ward, Peoria .....	1984
Richard Flacco, Galesburg .....	1985

### Fifth District

Robert Prentice, Springfield, *Trustee*  
Counties of DeWitt, Logan, McLean, Mason, Menard, Mont-  
gomery, Sangamon

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Richard H. Suhs, Springfield, <i>Chairman</i> .....	1983
Jack Means, Mason City .....	1984
A. L. Van Ness, Bloomington .....	1985

#### PEER REVIEW COMMITTEE

James Borgerson, Mt. Pulaski, <i>Chairman</i> .....	1983
George Irwin, Bloomington .....	1985
Paul Lafata, Springfield .....	1983
Robert B. Perry, Lincoln .....	1985
Donald Yurdin, Springfield .....	1985
Clifford Draper, Hillsboro .....	1985
Albert Cunningham, Normal .....	1983

### Sixth District

Robert R. Hartman, Jacksonville, *Trustee*  
Counties of Adams, Brown, Calhoun, Cass, Green, Jersey,  
Macoupin, Madison, Morgan, Pike, Scott

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Newton DuPuy, Quincy, <i>Chairman</i> .....	1983
Bernard Baalman, Hardin .....	1984
Edward K. DuVivier, Alton .....	1983
C. B. Lara, Pittsfield .....	1984
Robert Roy, Jacksonville .....	1984

#### PEER REVIEW COMMITTEE

Walter Stevenson III, Quincy, <i>Chairman</i> .....	1983
E. C. Bone, Jacksonville .....	1985
Robert England, Carlinville .....	1984
Robert C. Murphy, Quincy .....	1985
Edward Ragsdale, Alton .....	1983
James Sutherland, Quincy .....	1983
Robert F. Hamilton, Alton .....	1984

## Seventh District

Alfred J. Kiessel, Decatur, *Trustee*  
Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette,  
Macon, Marion, Moultrie, Piatt, Shelby

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Delbert H. Hahn, Jr., Decatur, <i>Chairman</i> .....	1985
P. D. L. Nayak, Effingham .....	1984
Muhammad T. Salaymeh, Taylorville .....	1985
E. F. Stephens, III, Centralia .....	1985

PEER REVIEW COMMITTEE	
M. K. Kaufman, Greenville, <i>Chairman</i> .....	1983
H. Gale Zacheis, Decatur .....	1983
Clarence G. Glenn, Decatur .....	1985
D. H. Rames, Vandalia .....	1985

## Eighth District

Arthur R. Traugott, Urbana, *Trustee*  
Counties of Champaign, Clark, Coles, Crawford, Cumberland,  
Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Mack W. Hollowell, Charleston, <i>Chairman</i> .....	1983
Charles L. Lansford, Urbana .....	1985
James H. Pass, Olney .....	1984
Stanley R. Huffman, Charleston .....	1983

PEER REVIEW COMMITTEE	
George T. Mitchell, Marshall, <i>Chairman</i> .....	1984
E. T. Baumgart, Danville .....	1983
G. Carr, Lawrenceville .....	1985
R. C. Adams, Champaign .....	1985

## Ninth District

Warren D. Tuttle, Harrisburg, *Trustee*  
Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton,  
Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski,  
Saline, Union, Wabash, Wayne, White, Williamson

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Alex Goldstein, Harrisburg, <i>Chairman</i> .....	1982
Eli Borkon, Carbondale .....	1983
Robert Rader, Anna .....	1983

PEER REVIEW COMMITTEE	
Philip D. Boren, Carmi, <i>Chairman</i> .....	1985
Larry Jones, Harrisburg .....	1984
Roger Klam, Carbondale .....	1984
Harry L. Lewis, Benton .....	1985
Eugene B. Loftin, Fairfield .....	1985
Charles K. Wells, Mt. Vernon .....	1985

## Tenth District

Thomas P. Meirink, Belleville, *Trustee*  
Counties of Monroe, Perry, Randolph, St. Clair, Washington

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
H. P. Dexheimer, Belleville, <i>Chairman</i> .....	1985
Roy Kenney, E. St. Louis .....	1985
Edilberto Maglasang, Columbia .....	1985
Wm. A. Simmons, Belleville .....	1985

PEER REVIEW COMMITTEE	
William H. Walton, Lenzburg, <i>Chairman</i> .....	1984
Benjamin Arenas, Belleville .....	1985
Ted Bryan, Belleville .....	1985
R. W. Jost, Waterloo .....	1984
R. E. Schettler, Red Bud .....	1983
Ron Welch, Belleville .....	1984

## Eleventh District

Kenneth Hurst, Naperville, *Trustee*  
Counties of DuPage, Ford, Grundy, Iroquois, Kankakee,  
Kendall, Will

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
James Ryan, Kankakee, <i>Chairman</i> .....	1985
Lawrence D. Lee, Manhattan .....	1985
Merle Otto, Frankfort .....	1985
William C. Perkins, West Chicago .....	1985

PEER REVIEW COMMITTEE	
James Campbell, Wheaton, <i>Chairman</i> .....	1984
James E. Dailey, Watseka .....	1984
Guy Pandola, Joliet .....	1984
A. G. Parkhurst, Kankakee .....	1983
W. H. Brill, Oswego .....	1983
Charles G. White, Naperville .....	1985
Alex Spadoni, Joliet .....	1985

## Twelfth District

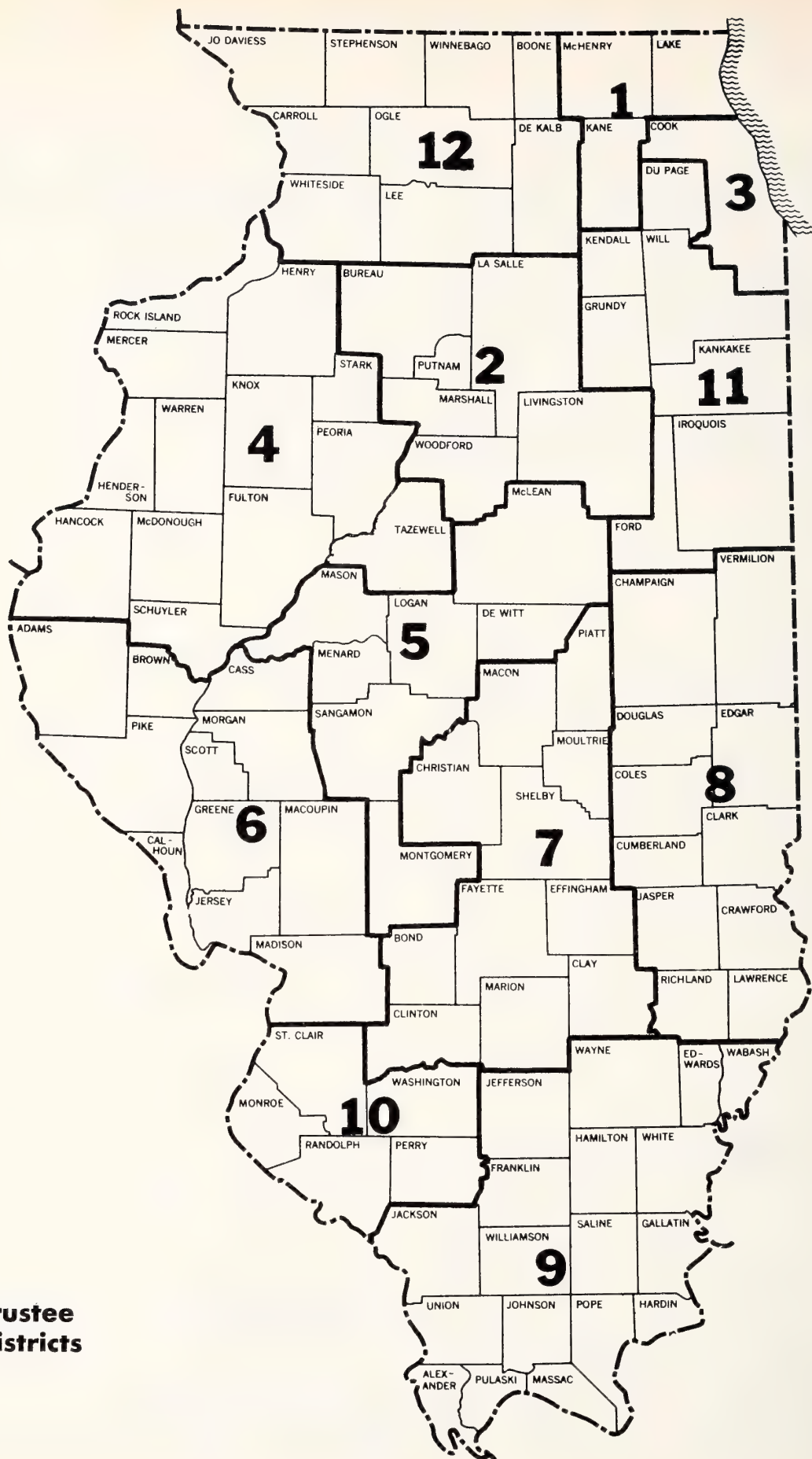
Joseph Perez, Rockford, *Trustee*  
Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle,  
Stephenson, Whiteside, Winnebago

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
P. John Seward, Rockford, <i>Chairman</i> .....	1983
John H. Steinkamp, Belvidere .....	1984
Frank Luedke, DeKalb .....	1984
Frank Descourouez, Freeport .....	1985

PEER REVIEW COMMITTEE	
P. John Seward, Rockford, <i>Chairman</i> .....	1983
Frank Luedke, DeKalb .....	1984
John H. Steinkamp, Belvidere .....	1984
Frank Descourouez, Freeport .....	1985



Trustee  
Districts



# ISMS HOUSE OF DELEGATES

## OFFICIAL MEMBERS OF THE HOUSE WITH THE RIGHT TO VOTE

### Officers of ISMS

President—Cyril C. Wiggishoff  
25 E. Washington, Chicago 60602  
President-Elect—Robert P. Johnson  
3000 Bennington, Springfield 62704  
Secretary-Treasurer—Jere Freidheim  
3050 S. Wallace, Chicago 60616  
First Vice President—Maynard I. Shapiro  
7531 Stony Island, Chicago 60649  
Second Vice President—Eugene P. Johnson  
P.O. Box 68, Casey 62420  
Speaker of the House—Clifton L. Reeder  
516 Sheridan Rd., Wilmette 60091  
Vice Speaker of the House—Julian Buser  
6600 W. Main St., Belleville 62223

### Board of Trustees

Chairman, Board of Trustees—Warren D. Tuttle  
203 N. Vine, Harrisburg 62946  
1st District—John J. Ring  
511 E. Hawley, Mundelein 60060 ..... 1984  
2nd District—Allan L. Goslin  
712 N. Bloomington, Streator 61364 ..... 1983  
3rd District—Alfred Clementi  
675 W. Central Rd.,  
Arlington Heights 60005 ..... 1985  
Audley F. Connor, Jr.  
7531 Stony Island Ave., Chicago 60649 ..... 1983  
Richard H. Blankshain  
715 Lake St., Oak Park 60301 ..... 1985  
Morris T. Friedell  
7531 Stony Island, Chicago 60649 ..... 1984  
Robert C. Hamilton  
25 E. Washington, Chicago 60602 ..... 1983

Henrietta Herbolsheimer  
1700 E. 56th Street, Chicago 60637 ..... 1984  
Lawrence L. Hirsch  
2434 Grace, Chicago 60618 ..... 1984  
Harold J. Lasky  
55 E. Washington, Chicago 60602 ..... 1983  
Richard Rovner  
645 N. Michigan, Suite 920, Chicago 60611... 1983  
Joseph C. Sherrick  
303 E. Superior, Chicago 60611 ..... 1983  
4th District—George Burke  
Rock Island Franciscan Hospital,  
2701 17th St., Rock Island 61201 ..... 1985  
5th District—Robert Prentice  
2248 Warson Rd., Springfield 62704 ..... 1985  
6th District—Robert R. Hartman  
1040 College, Jacksonville 62650 ..... 1984  
7th District—Alfred J. Kiessel  
One Powers Lane Place, Decatur 62522 ..... 1985  
8th District—Arthur R. Traugott  
602 W. University, Urbana 61801 ..... 1985  
9th District—Warren D. Tuttle  
203 N. Vine, Harrisburg 62946 ..... 1984  
10th District—Thomas Meirink  
8601 W. Main St., Belleville 62223 ..... 1984  
11th District—Kenneth A. Hurst  
52 Bunting Lane, Naperville 60565 ..... 1983  
12th District—Joseph Perez  
5670 E. State, Rockford 61108 ..... 1983  
Trustee-At-Large—Fred Z. White  
723 N. Second St., Chillicothe 61523 ..... 1983

### Representatives of County Societies

A complete listing of delegates and alternates to the ISMS House appears in the convention program.

## EX-OFFICIO MEMBERS OF THE HOUSE WITHOUT THE RIGHT TO VOTE

### Past Presidents

J. Ernest Breed\* ..... 1971  
Herschel Browns\* ..... 1981  
Edward W. Cannady\* ..... 1970  
Newton Dupuy\* ..... 1968  
Harlan English\* ..... 1964  
David S. Fox\* ..... 1979  
H. Close Hesselstine\* ..... 1961  
J. M. Ingalls ..... 1976  
Charles J. Jannings, III ..... 1972  
Frank J. Jirka, Jr.\* ..... 1973  
Fredric D. Lake\* ..... 1975  
Burtis E. Montgomery\* ..... 1966  
Caesar Portes\* ..... 1967  
Jacob E. Reisch (Honorary)\* ..... 1979  
Willard C. Scrivner\* ..... 1974  
P. John Seward\* ..... 1980

Joseph H. Skom\* ..... 1977  
Leo P. A. Sweeney\* ..... 1953  
Philip G. Thomsen\* ..... 1969  
Fred Z. White\* ..... 1982  
George T. Wilkins, Jr. .... 1978  
\*Also a past trustee or councilor

### Past Speakers

Walter C. Bornemeier, Chicago ..... 1962-1964  
Edward W. Cannady, Belleville ..... 1965-1967  
Maurice M. Hoeltgen, Chicago ..... 1968-1970  
Paul W. Sunderland, Gibson City ..... 1971-1973  
Andrew J. Brislen, Chicago ..... 1974-1975  
James A. McDonald, Geneva ..... 1975-1977  
Cyril C. Wiggishoff, Chicago ..... 1977-1979  
Robert P. Johnson, Springfield ..... 1979-1981

### Past Trustees

Walter C. Bornemeier  
Chicago, Trustee of the 3rd District  
Julian W. Buser  
Belleville, Trustee of the 10th District  
Raymond DesRosiers  
Chicago, Trustee of the 3rd District  
Herbert Dexheimer  
Belleville, Trustee of the 10th District  
Alfred Faber  
Northbrook, Trustee of the 3rd District  
Robert T. Fox  
Chicago, Trustee of the 3rd District  
Jere Freidheim  
Chicago, Trustee of the 3rd District  
George E. Giffin  
Princeton, Trustee of the 2nd District  
Lee N. Hamm  
Lincoln, Trustee of the 5th District

Eugene Hoban  
Chicago, Trustee of the 3rd District  
Ross Hutchison  
Gibson City, Trustee of the 11th District  
Eugene P. Johnson  
Casey, Trustee of the 8th District  
James Laidlaw  
Champaign, Trustee of the 8th District  
Ted LeBoy  
Chicago, Trustee of the 3rd District  
A. Edward Livingston  
Bloomington, Trustee of the 5th District  
Paul F. Mahon  
Springfield, Trustee of the 5th District  
Joseph R. O'Donnell  
Glen Ellyn, Trustee of the 11th District  
Mather Pfeiffenberger  
Alton, Trustee of the 6th District

Ralph N. Redmond  
Sterling, Trustee of the 2nd District  
George Shropshire  
Chicago, Trustee of the 3rd District  
Darrell H. Trumpe  
Springfield, Trustee of the 5th District  
Frederick E. Weiss  
Harvey, Trustee of the 3rd District  
Charles K. Wells  
Mt. Vernon, Trustee of the 9th District  
Cyril C. Wiggishoff  
Chicago, Trustee of the 3rd District  
Herman Wing  
Chicago, Trustee of the 3rd District  
Warren W. Young  
Chicago, Trustee of the 3rd District  
Paul P. Youngberg  
Moline, Trustee of the 4th District

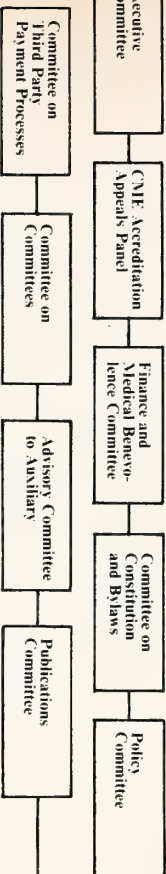


# HOUSE OF DELEGATES

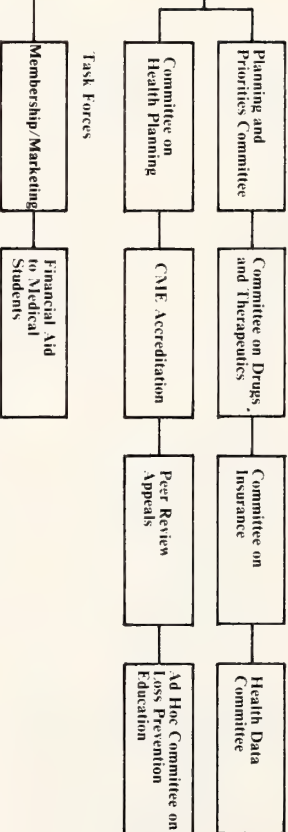
Judicial Panel

## BOARD OF TRUSTEES

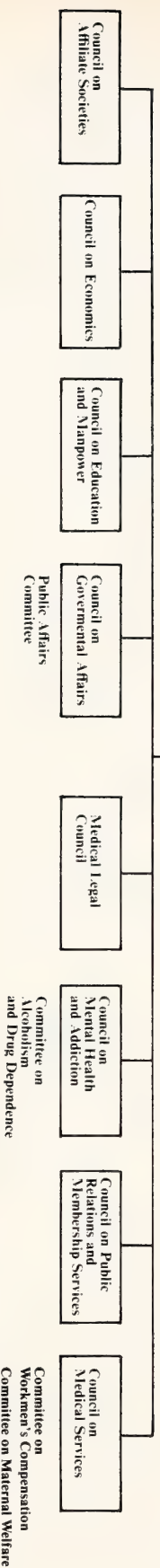
### Committees of the Board



### Direct Reporting Committees



### Councils and Committees



### Organizations Directly Related to ISMS

Illinois Foundation for Medical Care  
Illinois Council on Continuing Medical Education  
Illinois State Medical Benevolent Fund, Inc.  
Illinois State Medical Insurance Services, Inc.  
Illinois State Medical Inter-Insurance Exchange  
ISMS Educational and Scientific Foundation  
Medical Student Section  
Resident Physician Section

### Organizations with formal ISMS Representation

Swanberg Foundation  
Ill. Society, American Association of Medical Assistants  
Ill. Interagency Council on Smoking and Disease  
M.D. Committee on Optometry  
The Commission on Children  
INA/ISMS Joint Practice Comm.  
Ill. Medical Records Assn.  
Illinois Cancer Council  
Illinois Cooperative Health Data Systems  
Citizen's Committee on an Illinois Program to Control High Blood Pressure  
U. S. Pharmacopaeia  
Ill. Migrant Council  
Student Loan Fund Board, ISMS/TAA

# Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board committees. Some free standing committees may report directly to the board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, Speaker of the House, and Chairman of the Board are, by virtue of their office, *ex-officio* members of all groups.

## COUNCIL ON AFFILIATE SOCIETIES

Robert P. Johnson, Springfield, *Chairman*  
Ill. Sect., American College of OBGYN  
Jerome S. Beigler, Chicago  
Ill. Psychiatric Society  
Robert Borkenhagen, Indian Head Park  
Chicago Laryngological & Otolological Society  
Raymond L. DeFava, Evanston  
Ill. Radiological Society  
Raymond A. Dieter, Jr., Glen Ellyn  
Ill. Thoracic Surgical Society  
John M. Dietrich, Springfield  
Ill. Society of Pathology  
Patrick W. Elwood, Peoria  
Illinois Neurological Society  
Anthony G. Finder, Chicago  
Illinois Association of Ophthalmology  
Malachi Flanagan, Chicago  
Chicago Urological Society  
Gustav Giebelhausen, Peoria  
Ill. Chapter, American College of Surgeons  
William Gottschalk, Chicago  
Ill. Society of Anesthesiologists, Inc.  
Donald H. Hanscom, Hinsdale  
Ill. Society of Internal Medicine  
Donald R. Ingram, Alton  
Ill. Society of Ophthalmology and Otolaryngology  
William J. Kane, Chicago  
Ill. Orthopaedic Society  
Zena K. Lillian, Evanston  
Ill. Chapter, American Academy of Pediatrics

Robert C. Muehrcke, Oak Park  
Ill. Chapter, American College of Physicians  
David H. Paul, Belleville  
Ill. Chapter, American College of Emergency Physicians  
Jack R. Pickleman, Maywood  
Ill. Surgical Society  
Milton Robin, Chicago  
Ill. Dermatological Society  
Donald P. Schwartz, Flossmoor  
Allergy and Clinical Immunology Society of Ill.  
Stanley S. Smith, Urbana  
Ill. OBGYN Society  
Robert Swastek, Chicago  
Ill. Chapter, American Academy of Family Physicians

OTHER ORGANIZATIONS REPRESENTED:  
Illinois Surgical Society

CONSULTANTS:  
George H. Burke, Rock Island  
Eugene P. Johnson, Casey  
Harold J. Lasky, Chicago  
Joseph C. Sherrick, Chicago

### Responsibilities and Purposes:

To improve communication and provide liaison with the specialty societies; provide specialty consultation to other ISMS councils and committees; and to serve as a resource unit to ISMS on advances in the medical specialties.

## COUNCIL ON ECONOMICS

Ronald G. Welch, Belleville, *Chairman*  
Lorris M. Bowers, Peoria  
James R. DeBord, Peoria  
Bernard J. Feldman, Chicago  
Theodore Grevas, Rock Island  
A. Beaumont Johnson, Elgin  
Joseph M. Purpura, Winnetka  
David Shapiro, Libertyville  
Harry Springer, Winnetka

CONSULTANTS:  
Allan L. Goslin, Streator  
Alfred J. Kiessel, Decatur  
Maynard I. Shapiro, Chicago  
Arthur R. Traugott, Urbana

STUDENT  
Gail D. Williamson, Chicago

RESIDENT  
Raymond Maciejewski, Springfield

### Responsibilities and Purposes:

The Council on Economics considers issues regarding the costs, delivery and utilization of health care services. The council is interested in effective practice management and the economic impact of both government health policies and new health care delivery systems. The Council examines the impact of proposed new delivery systems and reports its recommendations to the Board.



## COUNCIL ON EDUCATION AND MANPOWER

Boyd McCracken, Sr., Greenville, *Chairman*

David Bristow, Effingham

Earl Fredrick, Olympia Fields

Mack Hollowell, Charleston

Ronald Johnson, Pleasant Hill

Eugene B. Loftin, Fairfield

Albert Maurer, Hopedale

Roger A. Nosal, Chicago

Aldo F. Pedroso, Skokie

Alan M. Roman, Blue Island

David Spindel, Chicago

Natalie Stephens, Chicago

### RESIDENT REPRESENTATIVE

John Diveris, Chicago

### STUDENT REPRESENTATIVE

Paula M. Olen, Brookfield

### IMGMA REPRESENTATIVE

Steven R. Perrigo, Springfield

### CONSULTANTS:

Lawrence L. Hirsch, Chicago

Robert P. Johnson, Springfield

Joseph C. Sherrick, Chicago

Fred Z. White, Chillicothe

### Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for allied health personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with medical students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

## GOVERNMENTAL AFFAIRS COUNCIL

P. John Seward, Rockford, *Chairman*

Lawrence Breslow, Northbrook

Harlan Faylor, Urbana

Edward G. Ference, Springfield

William D. Fish, Chicago

David S. Fox, Chicago

Jerome Frankel, Evanston

Henri Havdala, Chicago

William F. Hays, Herrin

Paul Mahon, Springfield

George T. Mitchell, Marshall

Tassos Nassos, Northbrook

John Ovitz, Sycamore

Edward Ragsdale, Alton

Jerry Ramunis, Galesburg

Herbert Sohn, Chicago

Alex Spadoni, Joliet

### AUXILIARY REPRESENTATIVE

Mrs. Alan Taylor, Danville

### STUDENT REPRESENTATIVE

Ronald Davis, Chicago

### RESIDENT REPRESENTATIVE

Nicholas Schlageter, Chicago

### CONSULTANTS:

George H. Burke, Rock Island

Robert R. Hartman, Jacksonville

Maynard I. Shapiro, Chicago

Arthur R. Traugott, Urbana

### ILLINOIS MEDICAL GROUP MANAGEMENT

### ASSOCIATION REPRESENTATIVE

Roger H. Stinson

### Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.

2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.

3. Co-operate with the AMA in similar programs.

4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

### Committees:

Public Affairs

## PUBLIC AFFAIRS COMMITTEE

Herbert Sohn, Chicago, *Chairman*

Herschel Browns, Chicago

Louis Dondanville, Moline

Edwin Falloon, Palos Heights

Delbert H. Hahn, Decatur

Don E. Hinderliter, Rochelle

Frank J. Jirka, Jr., Barrington Hills

James Laidlaw, Champaign

Sandra J. Olson, Chicago

Albert W. Ray, Jr., Joliet

Willard C. Scrivner, Belleville

A. E. Steer, Springfield

Mrs. Alan Taylor, Danville

George T. Wilkins, Edwardsville

### CONSULTANT:

Theodore Grevas, Rock Island

### IMGMA REPRESENTATIVE

Patrick Quigley, Springfield

### Responsibilities and Purposes:

The Public Affairs Committee is responsible for educating physicians about the political process and encouraging political involvement. The Committee also provides educational material on issues of interest to physicians and promotes physician involvement in public affairs activity.

## MEDICAL LEGAL COUNCIL

Morgan Meyer, Lombard, *Chairman*  
Robert Eilers, Evanston  
Saul Haskell, Chicago  
Herbert Henkel, Springfield  
Michael Murphy, Belleville  
Lawrence K. Richards, Urbana  
Sam Sugar, Evanston  
Robert Sumner, Harrisburg  
Hugo R. Velarde, Chicago  
Michael Victor, Buffalo Grove

### CONSULTANTS:

Richard H. Blankshain, Oak Park  
Eugene P. Johnson, Casey  
Thomas Meirink, Belleville  
Clifton L. Reeder, Wilmette

### RESIDENT REPRESENTATIVE

Frank Pieri, Berwyn

### STUDENT REPRESENTATIVE

James Kelly, Chicago

### Responsibilities and Purposes:

The Medical Legal Council shall cooperate with all organizations interested in medico-legal problems in order to educate members of the profession in medico-legal affairs. In addition, the council shall be concerned with standards of practice, licensure and quackery.

This council shall maintain liaison with the Illinois State Bar Association and cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel and the Worker's Compensation Roster. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

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## COUNCIL ON MEDICAL SERVICES

Wallace P. Berkowitz, Belleville, *Chairman*  
Serge Eytan, Chicago  
C. Larkin Flanagan, Chicago  
Adarsh Kumar, Springfield  
Meredith Murray, Oak Park  
H. Bates Noble, Chicago  
Daniel J. Pachman, Chicago  
Donald F. Pochly, Hines  
Eugene J. Rogers, Chicago  
Alan Stein, Alton  
Robert C. Stepto, Chicago  
Benjamin Williams, Urbana

### CONSULTANTS:

Alfred J. Clementi, Arlington Heights  
Henrietta Herbolzheimer, Chicago  
Eugene P. Johnson, Casey  
Joseph B. Perez, Rockford  
John J. Ring, Mundelein

### AUXILIARY REPRESENTATIVE

Mrs. Selig Hodes, Forrester

### STUDENT REPRESENTATIVE

Mark T. Donvito, Peoria

### RESIDENT REPRESENTATIVE

Mike Riermaier, Chicago

### Responsibilities and Purposes:

The Council considers a broad range of issues and programs related to medical facilities, professional health education, public health, laboratory services and services for the disadvantaged. Specific interest areas include nutrition, hospital-medical staff relations, emergency medical services, maternal and child welfare, workmen's compensation, and the penal health care services.

### Committees:

Laboratory Services  
Maternal Welfare  
Sports Medicine  
Workmen's Compensation

## COMMITTEE ON LABORATORY SERVICES

Benjamin Williams, Urbana, *Chairman*  
John Dietrich, Springfield  
Thomas Harwood, Elgin  
John Mason, Oak Lawn  
Richard Sasseti, Chicago  
Marshall Short, Chicago  
Peter Soto, Belleville  
Earl Suckow, Mt. Prospect  
Antoinette Thomas, Carbondale  
CONSULTANT:  
Alfred J. Kiessel, Decatur

### Responsibilities and Purposes:

The Committee shall monitor methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians and encourage each county and district to establish evaluation committees. It will cooperate with various state agencies in promoting a safe, adequate blood supply for the state.



## COMMITTEE ON MATERNAL WELFARE

### DISTRICT MEMBERS AND ALTERNATES

(alternates in italics)

1. Joseph Burke, Waukegan
2. Carl P. Mattioda, Streator  
*Ruthachai Rithaporn*, Princeton
3. Robert C. Stepto, Chicago, *Chairman*  
*Warren H. Staley*, Chicago
4. Raoul E. Reinertsen, Canton  
*Charles C. Egley*, Peoria
5. William H. Schultz, Springfield  
*Kofi S. Amankwah*, Springfield
6. Richmond H. Simmons, Jacksonville  
*Richard D. Yoder*, Alton
7. Herbert W. Thompson, Decatur  
*William L. Wagner*, Decatur
8. Lewis Trupin, Champaign  
*Larry R. Lane*, Champaign
9. William B. Skaggs, Harrisburg  
*Roger N. Klam*, Carbondale

10. Stephen V. Mueller, Belleville  
*Casimiro Garcia, Jr.*, Belleville
11. Kenneth M. Uznanski, Joliet  
*A. William Schafer*, Hinsdale
12. John E. Tillis, Rockford  
*Gordon T. Burns*, Rockford

### CONSULTANTS:

Robert R. Hartman, Jacksonville  
John Louis, Lake Forest  
Augusta Webster, Chicago

### Responsibilities and Purposes:

The primary responsibility of this committee is to review cases of maternal mortality in Illinois. This function is performed under a contract with the state health department. The Committee also deals with issues involving maternal health services and perinatal care.

## SPORTS MEDICINE COMMITTEE

H. Bates Noble, Chicago, *Chairman*  
Henry Dold, Arlington Heights  
Clarence Fossier, Lake Forest  
James L. Green, Jacksonville  
Ed Grogg, Urbana  
Joseph Hinkamp, Glenview  
J. M. Ingalls, Paris  
William T. Sheehy, Elgin  
Jacob Suker, Chicago  
Howard J. Sweeney, Evanston

### CONSULTANTS:

Audley Connor, Jr., Chicago

Robert C. Hamilton, Chicago

### AUXILIARY REPRESENTATIVE

Mrs. Harold Keegan, Kankakee

### Responsibilities and Purposes:

To conduct programs aimed at improving the recognition and treatment of athletic-related injury and disease; provide educational material to junior and senior high school coaches and trainers; and work with other groups and organizations involved in sports medicine activities.

## COMMITTEE ON WORKMEN'S COMPENSATION

Eugene J. Rogers, Chicago, *Chairman*  
Ernest Adams, Peoria  
Milton R. Carlson, Champaign  
Richard Geline, Skokie  
Forrest H. Riordan, III, Rockford  
Alvin Palow, Kankakee

Michael R. Treister, Chicago

### Responsibilities and Purposes:

The committee reviews how physicians are involved and affected by the Workmen's Compensation system in Illinois.

## COUNCIL ON MENTAL HEALTH AND ADDICTION

Douglas R. Bey, Normal, *Chairman*  
Richard Banta, Rockford  
Leroy Levitt, Chicago  
S. Dale Loomis, Chicago  
James V. Magnuson, Sterling  
Silvana Menendez, Belleville  
Edward Senay, Chicago (*IPS Liaison*)  
Mark Sinibaldi, Joliet  
(*Comm. on Alcoholism & Drug Dependence*)  
Garth Smith, Hinsdale  
Earl Solon, Des Plaines  
Robert Study, Chicago  
Kishore Thampy, Chicago

### CONSULTANTS:

Morris T. Friedell, Chicago  
Jere E. Freidheim, Chicago  
Kenneth A. Hurst, Naperville

### AUXILIARY REPRESENTATIVE

Mrs. Alex Spadoni, Hinsdale

### STUDENT REPRESENTATIVE

Dana Bracduinas, Chicago

### RESIDENT REPRESENTATIVE

Janice Polk, Chicago

### IDMHDD REPRESENTATIVE:

John Nelson, Elgin

### Responsibilities and Purposes:

This council shall serve as a source of information on mental health matters for ISMS, evaluate information and make recommendations to the Board of Trustees on positions ISMS should take on issues in this area, and cooperate with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse.

The council shall be on the alert for misleading or fallacious programs and information, and recommend appropriate action. It shall also be concerned with reviewing legislation and regulations related to the fields of mental health, alcoholism, drug abuse, and hazardous substances.

### Committee:

Alcoholism and Drug Dependence

## COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

Richard Banta, Rockford, *Chairman*  
Vincent Costanzo, Chicago  
Herbert Epstein, Glencoe  
Donald Sellers, Des Plaines  
Ruth Wharton, River Forest  
William Wehrmacher, Chicago

### CONSULTANTS:

Edward C. Senay, M.D., Chicago  
Linda Hargnett, DDC, Chicago  
J. Roalda Alderman, Div. of Alcoholism, Chicago

### AUXILIARY REPRESENTATIVE

Mrs. Don Hinderliter, Rochelle

### IMGMA REPRESENTATIVE

Barbara Birnbaum, Chicago

### Responsibilities and Purposes:

The Committee shall work closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs. The committee's functions include: (1) study, research and disseminate educational information on drugs and alcohol to members of the medical profession; (2) cooperate in the dissemination of information on the causes, prevention, diagnosis and treatment of alcoholism and drug dependence to the medical profession and to the public; (3) recommend acceptable measures for control of distribution and disposal of drugs and hazardous substances, exclusive of radiation products; and (4) cooperate with official and non-official agencies in all matters pertaining to this subject.

In April, 1977, ISMS established the Panel for the Impaired Physician. The Panel, which reports to the Committee on Alcoholism and Drug Dependence, consists of physicians who treat fellow physicians for problems related to alcohol or drug dependence, as well as impairment due to physical disabilities, mental or emotional disturbances.

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## COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Leo Wrona, Joliet, *Chairman*  
James Bauer, Peoria  
Albino Bismonte, Gurnee  
Brad L. Epstein, Chicago  
Reuben Ramkissoon, Hinsdale  
David A. Rothstein, Chicago

### CONSULTANTS:

Clifton L. Reeder, Wilmette  
Julian W. Buser, Belleville  
Robert L. Prentice, Springfield

### STUDENT REPRESENTATIVE

Crystal Cash, Chicago

### AUXILIARY REPRESENTATIVE

Mrs. Robert Reardon, Bloomington

### IMGMA REPRESENTATIVE

Roger Stinson, Chicago

### Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socioeconomic programs believed to be in the best interest of the profession as well as the general public. The council shall be responsible for new member orientation, exhibits and public service programming.



# Committees of the Board of Trustees

## ADVISORY COMMITTEE TO ISMS AUXILIARY

Fred Z. White, Chillicothe, *Chairman*  
Warren D. Tuttle, Harrisburg  
Robert P. Johnson, Springfield

### Responsibilities and Purposes:

The committee shall consist of the immediate past president

as chairman, the president, and the chairman of the Board. The committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members. It shall also monitor the services provided by ISMS to the Auxiliary.

## COMMITTEE ON COMMITTEES

Robert C. Hamilton, Chicago, *Chairman*  
Julian Buser, Belleville  
Lawrence L. Hirsch, Chicago  
Robert P. Johnson, Springfield  
Robert L. Prentice, Springfield

### Responsibilities and Purposes:

The Committee on Committees shall consist of members

of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

## COMMITTEE ON CONSTITUTION AND BYLAWS

Robert P. Johnson, Springfield, *Chairman*  
Robert C. Hamilton, Chicago  
Kenneth A. Hurst, Naperville  
Clifton L. Reeder, Wilmette  
Richard Rovner, Chicago

### Responsibilities and Purposes:

The Committee on Constitution & Bylaws shall:

- 1) Receive from individual members, county societies,

committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;

- 2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and

- 3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

## CME ACCREDITATION APPEALS PANEL

Richard Blankshain, Oak Park  
George H. Burke, Rock Island  
Morris T. Friedell, Chicago  
Robert R. Hartman, Jacksonville  
Henrietta Herbolzheimer, Chicago  
Harold J. Lasky, Chicago  
John J. Ring, Mundelein

### Responsibilities and Purposes:

In the event the Committee on CME Accreditation makes a non-accreditation decision to an Illinois CME sponsor, the sponsor may make a formal appeal to this hearing committee, which, in turn, will make a formal recommendation to the ISMS Board of Trustees on the sponsor's application.

## EXECUTIVE COMMITTEE

Warren D. Tuttle, Harrisburg, *Chairman*  
Jere Freidheim, Chicago  
Morris T. Friedell, Chicago  
Robert P. Johnson, Springfield  
Alfred J. Kiessel, Decatur  
Maynard I. Shapiro, Chicago  
Fred Z. White, Chillicothe  
Cyril C. Wiggishoff, Chicago

EX OFFICIO (without vote)  
Theodore Grevas, Rock Island

BY INVITATION (without vote)  
Clifton L. Reeder, Chicago

### Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of

the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer and the trustee-at-large. The immediate past chairman of the Board shall be a member, provided he is still a Trustee. If the immediate past chairman is no longer a Trustee, the chairman of the Policy Committee shall serve on the Executive Committee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

## FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

Alfred J. Kiessel, Decatur, *Chairman*  
Audley F. Connor, Chicago  
Jere E. Freidheim, Chicago  
Joseph Perez, Rockford

### AUXILIARY REPRESENTATIVE

Mrs. Louis Tarsinos

### Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It

shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Determine the allotment for each recipient.
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

## POLICY COMMITTEE

Lawrence L. Hirsch, Chicago, *Chairman*  
George Burke, Rock Island  
Harold J. Lasky, Chicago

### Responsibilities and Purposes:

The Policy Committee shall consist of three members of

the Board appointed by the chairman. It shall annually review all policy statements adopted five or more years previously and incorporate suggestions for revisions and deletions into resolutions for approval by the Board of Trustees and introduction in the House of Delegates. It shall also make recommendations for future policy by Board resolution to the House.

## PUBLICATIONS COMMITTEE

Joseph C. Sherrick, Chicago, *Chairman*  
Henrietta Herbolzheimer, Chicago  
Eugene P. Johnson, Casey  
Robert L. Prentice, Springfield  
John J. Ring, Mundelein

### Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editorial board in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, and shall review all new accounts prior to acceptance, and

shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

### IMJ Editorial Board

J. William Roddick, Jr., Springfield, *Chairman*  
Eli L. Borkon, Carbondale  
Raymond A. Dieter, Jr., Glen Ellyn  
Ediz Z. Ezdinli, Kenilworth  
Eugene J. Rogers, Chicago  
Constantine S. Soter, Northbrook  
David E. Trachtenbarg, Springfield  
Donald D. VanFossan, Springfield



## THIRD PARTY PAYMENT PROCESSES COMMITTEE

Fred Z. White, Chillicothe, *Chairman*  
Alfred J. Clementi, Arlington Heights  
Allan L. Goslin, Streator  
Thomas P. Meirink, Belleville  
Maynard I. Shapiro, Chicago  
Arthur R. Traugott, Urbana  
Cyril C. Wiggishoff, Chicago

ILL. MEDICAL GROUP MNGMT. ASSOC. REPS.

Mary M. Yarbrough, Chicago

### Responsibilities and Purposes:

The Committee on Third Party Payment Processes is a committee of the Board of Trustees. Its responsibility primarily is dealing with appropriate governmental and private entities on matters of direct and immediate economic concern to the practice of medicine. It monitors the activities of the Illinois Medicare program, the Illinois Department of Public Aid, the Illinois CHAMPUS program, Blue Cross/Blue Shield, other private insurers and corporations, and other appropriate entities (e.g., Foundation for Medical Care, etc.) which have a significant economic impact upon medicine. This Committee negotiates under the direction of the Board of Trustees to affect appropriate changes in economic programs and regularly reports to the Board of Trustees on its progress.

## Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

### COMMITTEE ON CME ACCREDITATION

Robert A. Behmer, Rockford, *Chairman*  
James H. Geist, Kankakee  
Terry F. Hatch, Urbana  
Walter F. Kondratowicz, Chicago  
Joseph P. McKay, Elmhurst  
Birendra K. Sinha, Elk Grove Village  
Dennis J. Stanczyk, Belleville

#### CONSULTANTS:

Audley F. Connor, Jr., Chicago

Maynard I. Shapiro, Chicago

### Responsibilities and Purposes:

Adopt necessary procedural rules and prescribe forms to be used in the conduct of CME accreditation, within prescribed policies. Review sponsor applications and survey team reports for intrastate CME sponsors, and make decision on grant of initial accreditation and continuation of accredited status.

## ILLINOIS CME SPONSORS ACCREDITED FOR CONTINUING MEDICAL EDUCATION AS OF SEPTEMBER 30, 1982

Alexian Brothers Medical Center—Elk Grove Village  
Augustana Hospital—Chicago  
Belleville Hospital Association for CME  
(Memorial Hospital, St. Elizabeth Hospital)  
Carle Foundation Hospital—Urbana  
Central Community Hospital—Chicago  
Central DuPage Hospital—Winfield  
Chicago Center Hospital  
Chicago College of Osteopathic Medicine  
Chicago Medical Society  
Chicago Pediatric Society  
Christ Hospital—Oak Lawn  
Columbus-Cuneo-Cabrini Medical Center—Chicago  
Community General Hospital—Sterling  
Community Memorial General Hospital—LaGrange  
Copley-Mercy CME Consortium—Aurora  
DuPage County Medical Society  
Elgin Mental Health Center  
FAB<sup>3</sup>-CME, (Forkosh Memorial, Belmont Community,  
Bethesda, Bethany Methodist, Thorek Medical Center)  
Chicago  
Forest Hospital—Des Plaines

Franciscan Medical Center—Rock Island  
Good Samaritan Hospital—Downers Grove  
Gottlieb Memorial Hospital—Melrose Park  
Grant Hospital of Chicago  
Henry Horner Childrens' Center—Chicago  
Highland Park Hospital  
Hinsdale Sanitarium & Hospital  
Holy Cross Hospital—Chicago  
Illinois Central Community Hospital—Chicago  
Illinois Council on Continuing Medical Education  
Illinois Heart Association  
Illinois Hospital Research & Educational Foundation-Illinois  
Hospital Association  
Illinois Masonic Medical Center—Chicago  
Illinois Society of Allergy and Clinical Immunology  
Ingalls Memorial Hospital—Harvey  
Institute for Psychoanalysis—Chicago  
Jackson Park Hospital—Chicago  
Kishwaukee Community Health Center—DeKalb  
Lake Forest Hospital  
Loretto Hospital—Chicago  
Louis A. Weiss Memorial Hospital—Chicago

Loyola University Stritch School of Medicine—Maywood  
 Lutheran Hospital—Moline  
 Lutheran General Hospital—Park Ridge  
 MacNeal Memorial Hospital—Berwyn  
 Martha Washington Hospital—Chicago  
 Mary Thompson Hospital—Chicago  
 Mazel Medical Center—Edgewater Hospital—Chicago  
 Memorial Hospital of DuPage County—Elmhurst  
 Mercy Hospital & Medical Center—Chicago  
 The Methodist Medical Center of Illinois—Peoria  
 Mount Sinai Hospital Medical Center of Chicago  
 Northwestern University Medical School—Chicago  
 North Shore Mental Health Association/Irene Josselyn  
 Clinic—Northfield  
 Northwest Hospital—Chicago  
 Northwest Community Hospital—Arlington Heights  
 Norwegian-American Hospital—Chicago  
 Oak Forest Hospital  
 Oak Park Hospital  
 Provident Hospital—Chicago  
 Ravenswood Hospital Medical Center—Chicago  
 Resurrection Hospital—Chicago  
 Riveredge Hospital—Forest Park  
 Riverside Hospital—Kankakee  
 Rockford Memorial Hospital  
 Rush Medical College—Chicago  
 Sarah Bush Lincoln Health Center—Mattoon  
 Sherman Hospital—Elgin

Shriner's Hospital for Crippled Children—Chicago  
 Silver Cross Hospital—Joliet  
 Skokie Valley Community Hospital—Skokie  
 South Chicago Community Hospital  
 Southern Illinois University School of Medicine—Springfield  
 St. Anne's Hospital—Chicago  
 St. Anthony Hospital—Chicago  
 St. Anthony Hospital—Rockford  
 St. Elizabeth's Hospital—Chicago  
 St. Elizabeth Hospital—Danville  
 St. Francis Hospital—Blue Island  
 St. Francis Hospital-Medical Center—Peoria  
 St. Joseph Hospital—Chicago  
 St. Joseph Hospital—Elgin  
 St. Mary's Hospital—Kankakee  
 St. Mary's Hospital—Streator  
 St. Mary of Nazareth Hospital—Chicago  
 St. Therese Hospital—Waukegan  
 Suburban Medical Center—Hoffman Estates  
 SwedishAmerican Hospital—Rockford  
 Swedish Covenant Hospital—Chicago  
 University of Chicago Pritzker School of Medicine  
 University of Health Sciences/The Chicago Medical School  
 University of Illinois College of Medicine  
 Victory Memorial Hospital—Waukegan  
 Westlake Community Hospital—Melrose Park  
 West Suburban Hospital—Oak Park  
 Woodlawn Hospital—Chicago

## COMMITTEE ON DRUGS AND THERAPEUTICS

Joseph H. Skom, Chicago, *Chairman*  
 Andrew Brislen, Chicago  
 Amin N. Daghestani, Skokie  
 Ignacio DelValle, Taylorville  
 Dorothy Hubler, Casey  
 John Hyde, Oak Park  
 Robert Reeder, St. Charles

### CONSULTANTS:

Vincent A. Costanzo, Jr., Chicago  
 A. Samuel Enloe, R.Ph., Decatur

Kerrison Juniper, Springfield  
 Dawn Atkins-Gottrich, IDPA

### Responsibilities and Purposes:

The committee shall meet periodically to review the listing of pharmaceutical products in the IDPA Drug Manual. When it deems it necessary to list new products in the Manual, the committee shall request the Board of Trustees to approve and forward its recommendations to the Illinois Department of Public Aid. Comments or suggestions made by the membership regarding drugs are reviewed by the committee.

## HEALTH DATA COMMITTEE

Andrew Brislen, Chicago, *Chairman*  
 Audley F. Connor, Jr., Chicago  
 Alexander Goldstein, Harrisburg  
 Allan Goslin, Streator  
 Donald H. Hanscom, Hinsdale  
 Henrietta Herbolzheimer, Chicago  
 James Laidlaw, Champaign  
 Joseph R. O'Donnell, Glen Ellyn  
 Paul Peterson, Chicago  
 Clifton L. Reeder, Wilmette  
 Walter Stevenson, Quincy  
 Ben T. Williams, Urbana  
 CONSULTANT:  
 Alexander R. Lerner

### Responsibilities and Purposes:

The committee shall maintain ongoing awareness of: (1)

systems for the collection and dissemination of health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of PSROs, HSAs, the Illinois Cooperative Health Data System (ICHDS), governmental agencies and others with respect to the collection and dissemination of health care data. To the extent feasible, the Committee shall provide informal liaison between the foregoing organizations and ISMS. The committee shall keep the officers, Board of Trustees and other appropriate persons within ISMS advised on data collection matters.



## COMMITTEE ON HEALTH PLANNING

Samuel L. Andelman, Skokie, *Chairman*

Ronald F. Albrecht, Chicago

Eli L. Borkon, Carbondale

Robert D. Dooley, Oak Brook

Norris R. Dougherty, Rockford

Gerald W. Grawey, Peoria

Donald E. Lighter, Pekin

Robert M. Vanecko, Chicago

Richard C. Wanless, Belleville

Charles K. Wells, Mt. Vernon

### CONSULTANTS:

George H. Burke, Rock Island

Audley F. Connor, Jr., Chicago

Henrietta Herbolsheimer, Chicago

Alfred J. Kiessel, Decatur

Joseph R. O'Donnell, Glen Ellyn

Clifton L. Reeder, Wilmette

Fred Z. White, Chillicothe

AUXILIARY REPRESENTATIVE

Mrs. Harlan Failor, Champaign

IMGMA REPRESENTATIVE

Darlene Duff, Chicago

### Responsibilities and Purposes:

The Committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local areawide health planning agencies. The Committee also monitors the health care coalition movement and reports to the Board on coalition activities.

## COMMITTEE ON INSURANCE

Gerald S. Modjeska, Chicago, *Chairman*

Anne L. Barlow, N. Chicago

William Henry, Springfield

Warren C. Jenkins, Northbrook

Arthur R. Marks, Fairfield

### CONSULTANTS:

Richard H. Blankshain, Oak Park

Phillip Boren, Carmi

Joseph B. Perez, Rockford

Clifton L. Reeder, Wilmette

Arthur R. Traugott, Urbana

IMGMA REPRESENTATIVE

Gerald T. O'Brien, Chicago

### Responsibilities and Purposes:

The Committee on Insurance monitors the ISMS-sponsored insurance programs for members. Current policies and new types of insurance programs are evaluated in order to recommend changes that may benefit society members. The Committee works closely with the programs' administrator, Corroon & Black, Inc.

## AD HOC COMMITTEE ON LOSS PREVENTION EDUCATION

Alfred J. Clementi, Arlington Heights, *Chairman*

Donald Aaronson, Chicago

Phillip Boren, Carmi

Clinton Compere, Chicago

Robert R. Hartman, Jacksonville

Clifton L. Reeder, Chicago

Richard Wilbur, Lake Forest

### Responsibilities and Purposes:

The ad hoc Committee on Loss Prevention Education seeks to help physicians identify legal dicta and court procedures and the application of these to medical practice. It seeks to enable physician identification of potential problems in various medical procedures and practice settings and effect a change in same. Educational efforts are intended to improve the quality of medical care and prevent law suits.

## PEER REVIEW APPEALS COMMITTEE

George J. Gertz, Chicago, *Chairman*

Eugene T. Hoban, Oak Park

Carl Johnson, Moline

Harry L. Lewis, Benton

Pedro Poma, Melrose Park

Lloyd E. Thompson, East St. Louis

Charles Wells, Mt. Vernon

### Responsibilities and Purposes:

This committee serves as the appellate body for cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relations issues. The committee is the State Society's liaison to local peer review committees and monitors review activities around the state.

## PLANNING AND PRIORITIES COMMITTEE

Robert P. Johnson, Springfield, *Chairman*  
Richard Blankshain, Oak Park  
Lorris M. Bowers, Peoria  
Julian Buser, Belleville  
Jere E. Freidheim, Chicago  
Robert C. Hamilton, Chicago  
Henrietta Herbolsheimer, Chicago  
Morgan M. Meyer, Lombard  
Albert W. Ray, Jr., Joliet  
John J. Ring, Mundelein  
Harry Springer, Winnetka

Arthur Traugott, Urbana

### Responsibilities and Purposes:

The President-Elect shall serve as the chairman of the Committee on Planning and Priorities. This Committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President.

## TASK FORCE ON FINANCIAL AID TO MEDICAL STUDENTS

Fred Z. White, Chillicothe, *Chairman*  
Julian W. Buser, Belleville  
Robert P. Johnson, Springfield

Eugene P. Johnson, Casey  
Malcolm Major, Urbana  
Cyril C. Wiggishoff, Chicago

## TASK FORCE ON MEMBERSHIP/MARKETING

Cyril C. Wiggishoff, M.D., Chicago, *Chairman*  
Brad Epstein, M.D., Chicago  
Robert C. Hamilton, M.D., Chicago  
Eugene P. Johnson, M.D., Casey  
Robert P. Johnson, M.D., Springfield  
Clifton L. Reeder, M.D., Wilmette  
Fred Schwartz, Chicago  
Linda Tetzlaff, Chicago  
Lillian Widmer, Glen Ellyn

### Responsibilities and Purposes:

The Task Force on Membership/Marketing shall work to (1) retain current ISMS members and recruit new ISMS members; (2) build future membership through residents and medical student members; (3) coordinate with county medical societies retention and recruitment of mutual members; (4) cooperate with the American Medical Association to retain and recruit mutual members and (5) enhance membership in organized medicine through quality programming and communication.

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in this issue. Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

NAME: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
TELEPHONE: (    ) \_\_\_\_\_  
COUNTY MEDICAL SOCIETY: \_\_\_\_\_  
MEDICAL SPECIALTY AND TYPE OF PRACTICE: \_\_\_\_\_  
COMMITTEE IN WHICH INTERESTED: \_\_\_\_\_  
EXPERTISE FOR THIS COMMITTEE: \_\_\_\_\_

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society  
55 E. Monroe, Suite 3510, Chicago, IL 60603



## Direct Reporting Committees of the House of Delegates

### JUDICIAL PANEL COMMITTEE

	<i>Term Expires</i>
Frank B. Norbury, Jacksonville, <i>Chairman</i>	1983
Donald Aaronson, Niles	1984
Allison Burdick, Jr., Oak Park	1984
Eugene P. Johnson, Casey	1986
Eugene T. Leonard, Rockford	1985

#### **Responsibilities and Purposes:**

The Panel, whose members are nominated by the President and elected by the House of Delegates, adjudicates disputes arising from charges of unethical or illegal practices. The panel accepts appeals after a case has been heard at the county or district level.

## Other Appointments and Representatives

### REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Jack Gibbs, Canton, *Chairman*  
Albert G. Bledig, Eldorado  
Thomas Schrepfer, Havana

#### **Responsibilities and Purposes:**

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

### REPRESENTATIVES TO ILLINOIS COOPERATIVE HEALTH DATA SYSTEMS

Audley F. Connor, Jr., Chicago  
Alexander Goldstein, Harrisburg  
Allan L. Goslin, Streator  
Donald H. Hanscom, Hinsdale  
Henrietta Herbolsheimer, Chicago

Alexander R. Lerner, *Executive Administrator*, ISMS  
Joseph R. O'Donnell, Glen Ellyn  
Clifton L. Reeder, Wilmette  
Walter Stevenson, Quincy  
Ben T. Williams, Urbana

### REPRESENTATIVES TO INA-ISMS JOINT PRACTICE COMMITTEE

Loren Boon, Danvers  
Robert Libman, Chicago  
Allan Goslin, Streator  
Risher Watts, Chicago

#### **Responsibilities and Purposes:**

The purposes and objectives of the committee shall be to:  
(1) improve communication between medicine and nursing

to enhance joint planning and action; (2) examine roles and functions in medical and nursing practice with definition of new and altered patterns; (3) propose changes in educational patterns and relationships that would enhance the new role functioning of nurses and physicians; (4) define, identify and examine health care needs; (5) address the traditional problems which affect nurse-physician relationships in order to establish enhanced role functioning, and (6) identify and address the ensuing problems related to basic role reorganization.

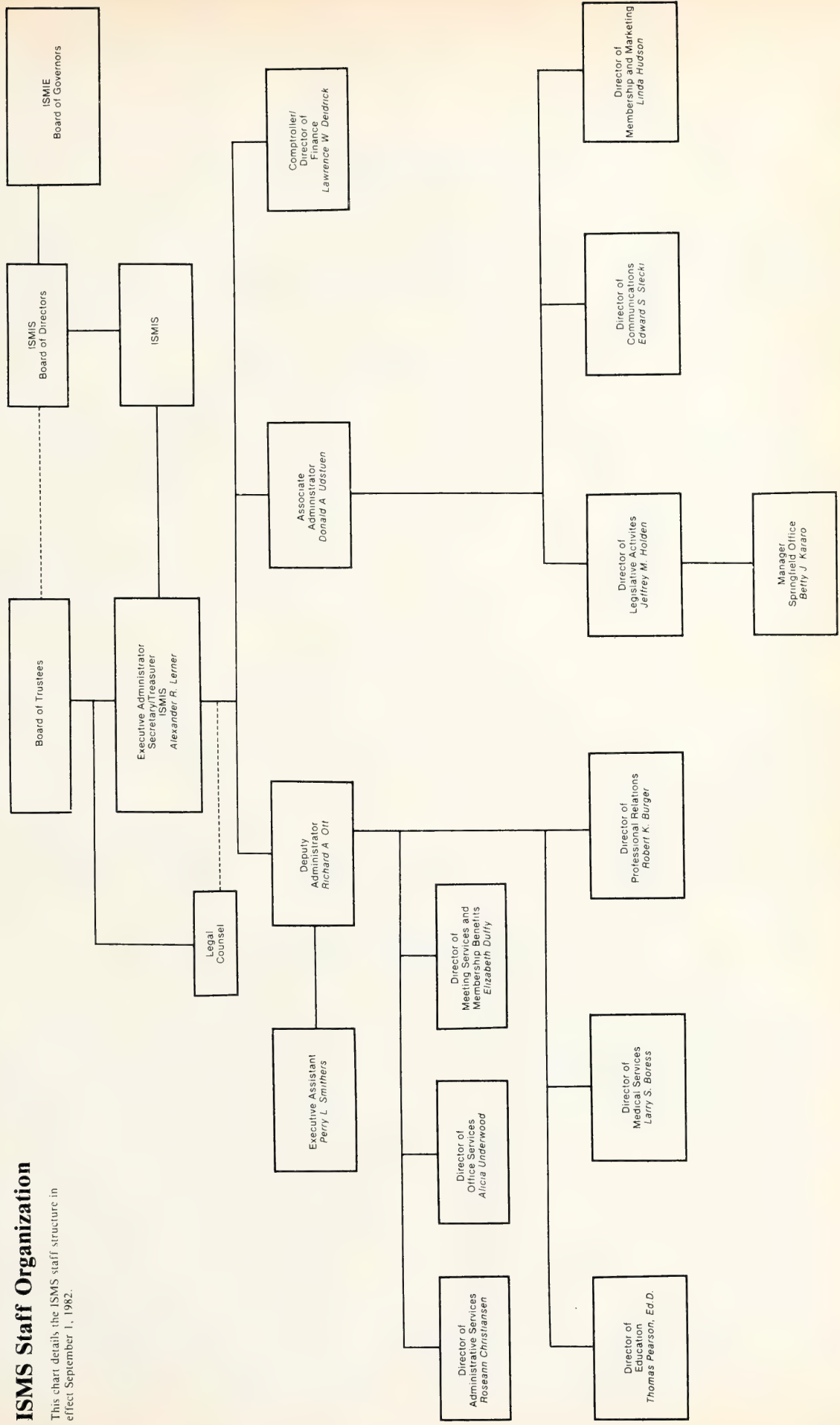
### ISMS REPRESENTATIVES TO OTHER GROUPS

SWANBERG FOUNDATION, QUINCY  
Robert R. Hartman, Jacksonville  
LIAISON TO ILL. SOC. OF THE AMER. ASSOC.  
OF MED. ASSTS.  
Robert R. Hartman, Jacksonville  
ILL. INTERAGENCY COUN. ON SMOKING AND DISEASE  
Charles L. Swarts, Oak Park  
ILLINOIS MEDICAL RECORDS ASSOC.  
Clifton Reeder, Wilmette  
ILLINOIS MIGRANT COUNCIL  
Fred Z. White, Chillicothe  
MD COMMITTEE ON OPTOMETRY  
Joel Kaplan, Chicago

STATEWIDE COOPERATING ORGANIZATIONS  
COMMITTEE OF THE  
COMMISSION ON CHILDREN  
William Elbers, Peoria  
ILLINOIS CANCER COUNCIL  
Peter Friedell, Chicago  
CITIZENS COMMITTEE FOR AN ILLINOIS PROGRAM  
TO CONTROL HIGH BLOOD PRESSURE  
David Berkson, Chicago  
U.S. PHARMACOPAEIA  
Joseph Skom, Chicago, *Delegate*  
Vincent Costanzo, Chicago, *Alternate*

# ISMS Staff Organization

This chart details the ISMS staff structure in effect September 1, 1982.





# ISMS SERVICES

*Members of the Illinois State Medical Society benefit from a range of programs, publications and services. This section is designed to describe the activities and organization of the Society and benefits of membership, and reflects staff organization as of October 1, 1982.*

## ADMINISTRATION

The Executive Administrator is responsible for the implementation of established policy, fiscal, budgetary and personnel matters. Specifically, he:

- \* provides liaison with the Board of Trustees and implements their actions
- \* evaluates legal inquiries for referral to the general counsel
- \* has final authority for management team program planning and implementation
- \* provides guidance to officers, trustees, committee

- chairmen and county medical society officers
- \* directs activity and organization of personnel
- \* acts as secretary-treasurer for Illinois State Medical Insurance Services

Administrative staff also offer direct support to the House of Delegates, Executive Committee, Policy Committee, Committee on Constitution and Bylaws, other Board Committees and the Educational and Scientific Foundation.

## MANAGEMENT

Society programs, issues and activities are coordinated administratively through the delegation of managerial authority. The Deputy Administrator and Associate Administrator administer this responsibility under the direction of the Executive Administrator.

The Deputy Administrator directs the activities of the divisions of Education, Professional Relations and Medical

Services. In addition, the Deputy Administrator directs the activities of office, administrative and meeting services.

The Associate Administrator directs the divisions of Legislative Activities, Communications and Membership/Marketing Services. In addition, the Associate Administrator has responsibility for public and governmental affairs.

## MEMBERSHIP BENEFITS

A number of programs and services are provided to Society members or sponsored for their benefit. These include the 50-Year-Club, meeting services and travel programs.

- \* The *50-Year-Club* consists of physicians who graduated from medical school more than 50 years ago. An annual luncheon gives these members an opportunity to renew friendships.
- \* *ISMS meeting services* include provision for assemblies of the House of Delegates and Board of Trustees. Councils and committees meet in the headquarters office.
- \* Society-sponsored *travel programs* enable members to enjoy luxury cruises and tours at minimum cost. Qualified tour agencies are screened for professional, non-regimented trips.

### New Physicians

Medical students and residents have formed affiliate sections within the Society. ISMS also conducts several programs for new physicians and those seeking either a medical education or an opportunity to practice in Illinois.

- \* The *Physician Recruitment Program* seeks to link

communities in need of a physician with those seeking practice opportunities. Questionnaires on educational background, interests and practice preference are distributed to physicians who receive a complete list of openings in return. Communities seeking physicians contact the service for like information.

- \* The *Medical Student Loan Fund Program* is a joint effort of ISMS and the Illinois Agricultural Association. The Medical Student Loan Fund Board screens students whose college grades or MCAT scores are marginal and recommends special consideration by the UI College of Medicine in selected cases. In return, the student promises to practice in a rural community needing a physician for four or five years after graduation. The program also makes low interest loans available to students. Repayment is delayed until four years after graduation and the student makes a similar agreement to practice for a period in rural Illinois.
- \* The *MECO* (Medical Education Community Orientation) program seeks to encourage students to select careers in primary care.

## FINANCE

Also part of the management team is the Director of the Division of Finance, who also serves as comptroller for Illinois State Medical Insurance Services, Inc. This division maintains electronic data processing capability for appropriate automation of accounting records, membership files and professional liability insurance data, as well as management of personnel records.

Financial management services are conducted under policies set by the Board of Trustees and the Finance Committee and include maintaining financial records, monitoring investments and securing the assets of the Society, the Illinois State Medical

Insurance Services, Inc. and the Illinois State Medical Inter-Insurance Exchange.

Central to the financial management activities is the Society's computer services which provide a cost-effective method to:

- \* maintain membership records
- \* provide central dues billing and collection for county medical societies
- \* catalogue claim statistics and other data for the Illinois State Medical Insurance Services, Inc.
- \* process financial records
- \* provide word processing capability

## EDUCATION

The Society monitors changes in medical education, post-graduate requirements for licensure and accreditation procedures. Educational matters are addressed through staff services to the Illinois Council on Continuing Medical Education,

ISMS Council on Education and Manpower and Committee on CME Accreditation. Liaison with appropriate state agencies assures that members can be assisted in fulfilling licensure requirements and procedures.

## COMMUNICATIONS

The Society provides information to the ISMS membership and news media through various mechanisms:

- \* Speeches, slide presentations and brochures are prepared under direction of the Council on Public Relations and other committees
- \* News releases publicize ISMS actions and views
- \* Public service announcements are designed and distributed to Illinois radio and television stations

A number of publications are produced in the Society offices for members of ISMS and affiliated groups.

- \* The *Illinois Medical Journal* is published monthly under direction of a Publications Committee and clinical supervision of an Editorial Board. The *Journal* seeks to keep members aware of scientific, economic, legal and political events.
- \* *Action Report*, a periodic newsletter, focuses on Society activities and economic matters.
- \* *On the Legislative Scene* is a newsletter available on request during the General Assembly session. *OLS* gives status reports on pending legislation of importance to physicians.
- \* *AID* (Athletics, Injury and Disease) is a newsletter for coaches and trainers. It gives sports-medicine in-

formation in prevention, recognition and triage of injuries and illnesses. *AID* is published three times annually and distributed to about 2000 junior and senior high school coaches and trainers.

- \* The *Exchange Commentary*, published by the Illinois State Medical Inter-Insurance Exchange, updates ISMIE members on professional liability issues.
- \* *Pulse of the ISMS Auxiliary* is a quarterly publication of the 3,000 member ISMS Auxiliary. It features membership activities and items of interest to physician spouses.
- \* Affiliate group newsletters include the Illinois Psychiatric Society *Examiner*, which won a national editorial award in 1980. Other affiliate groups publishing newsletters through Society services are the Illinois Academy of Pediatrics, Illinois Society of Internal Medicine, Illinois Association of Ophthalmology and Illinois Society, American Association of Medical Assistants.

In addition to publications, the Society provides services to affiliated groups on a cost allocated basis. These include routine office management, meeting arrangements, membership promotion and records, dues collection and accounting services.



## MEDICAL SERVICES

The delivery of medical care, through various types of facilities, health delivery systems, programs and agencies is the continuing concern of the ISMS Councils and Committees. Additionally, the prevailing medical-legal, ethical and practice management issues are also dealt with by membership committees.

The Society's new emphasis is centering around the problems and issues affecting hospital medical staffs. Programs and materials to assist staffs and their members are developed as needs become identified. ISMS is a resource for all practice matters in Illinois.

Serving the needs of the public also is a function of the Society. Patient information materials on medical, social and economic topics are developed through councils and committees and disseminated through members' offices. In addition, the Society offers consultative services to correctional agencies in the development and improvement of health care systems in penal environments.

Finally, ISMS provides an opportunity for physicians to serve as physician expert witnesses to Illinois courts and the state's Industrial Commission, so impartial medical evaluations can be provided in disputed cases.

## PROFESSIONAL RELATIONS

The Society provides direct services to members through field service representatives. These persons represent ISMS at meetings of component societies, allied professions and government agencies. They serve trustees, officers, county medical society executives and the general membership. Specific professional relations activities include the following:

- \* *President's Tour*—The ISMS president visits each trustee district during his term of office. The tour includes press conferences, interviews and speaking engagements.
- \* *Medicare, Medicaid and CHAMPUS Assistance*—Medicare peer review and professional relations services are provided. Liaison with the Illinois Department of Public Aid assures that member concerns are represented when policy changes are considered. Assistance can be provided in payment delays, reimbursement

errors, lost billings and fiscal audits.

- \* *Health Planning*—Actions of the Statewide Health Coordinating Council, Illinois Health Facilities Planning Board and local Health Systems Agencies are followed closely.
- \* *Third Party Payors*—The Council on Economics and Committee on Third Party Payment Processes direct association with insurance carriers and government bodies that affect their actions.
- \* *Health Data*—Government requirements for statistical information on health care and planning agencies in that area are monitored.
- \* *Assistance with Private Insurers*—The division is available to assist members with questions or problems related to private insurance.

## LEGISLATIVE ACTIVITIES

One in five bills introduced in the General Assembly relates to health. The Society's active legislative program is conducted under direction of the Governmental Affairs Council.

All state and national health legislation is monitored. Society staff forward bills to physician members with pertinent expertise for review and comment. When adequate review is completed and appropriate positions are developed, legislative representatives express the ISMS position to legislators, as well as continually monitor amendments to bills of interest to medicine.

Physicians who testify before legislative committees provide essential background to lawmakers. Additional input and citizen involvement are developed through the Key Man Program and public affairs activity.

- \* *The Key Man Program* is a network of physicians or spouses who are relatives, friends or campaign supporters of Illinois legislators. "Key men" advise legislators on health legislation.
- \* *Public affairs activity* includes sponsorship of civic speakers at Society meetings and liaison with government agencies.

## COMMERCIAL INSURANCE PROGRAMS

The ISMS Insurance Committee has selected insurance programs which are administered by an independent broker. Each has been scrutinized for quality and economy. Detailed information on ISMS insurance plans and applications may be obtained through the broker, Corroon and Black of Illinois,

Inc., 135 S. LaSalle St., Chicago IL 60603; (312-621-4909).

It is recommended that members check with ISMS or its broker before purchasing any insurance. A brief synopsis of each program follows.

### Group Term Life Insurance

The group term life insurance program is underwritten by the North American Company for Life and Health Insurance. It offers:

- \* \$25,000 to \$1 million in level term life insurance
- \* built-in waiver of premium
- \* availability to members, their spouses and employees under age 65
- \* coverage to \$5,000 for members' children
- \* non-cancellable, guaranteed renewability to age 100
- \* conversion to permanent individual policy guaranteed to age 65

### Group Disability Income Protection Program

The group disability income protection program is underwritten by the Commercial Insurance company. It provides:

- \* \$500-\$3,000/month for total disability
- \* coverage renewable to age 70
- \* benefit period options of lifetime accident and sickness
- \* payable (1) to age 65; (2) for seven years; (3) five year accident and sickness payable for 2 years
- \* available to members and authorized employees or insured members to age 55
- \* benefits payable regardless of other insurance
- \* no restrictive riders attached after issuance
- \* individual coverage cannot be terminated

### Professional Overhead Expense Plan

This new plan is underwritten by the Hartford Accident and Indemnity Company and provides

- \* \$500-\$5,000/month coverage
- \* office overhead expenses paid to maximum benefit selected beginning with 31st day of total disability
- \* benefits payable to 24 months regardless of other insurance
- \* new—accumulation benefit provided
- \* guaranteed issue for qualified new members under age 40 who apply within 60 days of effective date of membership
- \* available to all members under age 65 in full time practice
- \* rent, utilities, employee salaries and monthly pro rata of specified annual fixed expenses customary to the profession
- \* premiums deductible for individuals and partnerships under Revenue Ruling 55-264

The plan does not cover personal income, salaries for other physicians, principal payments on debts, implements, pharmaceutical products and personal insurance premiums.

### Group Major Medical

The group major medical plan is underwritten by the Commercial Insurance Company. It provides that the insured select a calendar year deductible of \$500 or \$1000, which applies to each insured person. It then will *cover 80% of the following*:

- \* \$150/day room and board rate
- \* (additional) \$150/day in an ICU
- \* hospital supplies and services, physician services, anesthesiologists, diagnostic lab and X-ray, registered nurses, ambulance services, prescription drugs and medicines, physiotherapy, therapeutic equipment rentals, artificial limbs, oxygen and blood.

The plan is available to all members and qualified employees of insured members under age 65.

### Excess Major Medical

This plan, underwritten by the Sentry Insurance Company,

pays 100% of eligible medical expenses to ten years or \$500,000. Selection of a \$15,000, \$20,000 or \$25,000 deductible is available. The plan comes into effect when eligible medical expenses incurred within a three year period exceed the deductible. Evidence of insurability is not required. The plan will compensate up to 100% of the following:

- \* medical care
- \* physician medical care and treatment
- \* semi-private room and board
- \* private duty nursing services
- \* convalescent home confinement (up to \$50/day and 90 days/year)
- \* physiotherapy by licensed physiotherapist
- \* prescription drugs, medicine and antibiotics
- \* dressings, casts, splints, trusses, braces and crutches; rental of wheelchair, hospital-type bed, iron lung and other therapeutic equipment; blood and blood plasma; X-ray and other radiotherapy; diagnostic tests and examinations; dental care for accidental injury of natural teeth; oxygen and anesthesia; ambulance service to \$200 in any six month period; assistant surgeon to 20% of eligible expenses for chief surgeon; anesthesiologist to 15% of eligible expenses of chief surgeon.

The plan is available to members and their spouses, unmarried children under 25 and eligible full time employees under 65. Eligible applicants are guaranteed acceptance subject to a preexisting conditions limitation.

### Hospital Indemnity Plan

The Hartford Accident and Indemnity Company underwrites the ISMS-sponsored hospital indemnity plan. Available plans provide benefits of \$27.50, \$55.00, \$110.00 or \$165 per day of hospital confinement. Benefits are also:

- \* initiated with first day of confinement
- \* payable to 365 days for each cause of confinement
- \* automatically doubled for hospital stays due to cancer or confinement in an ICU for persons under age 65
- \* payable regardless of other insurance

All members, their employees and families may participate. Acceptance of eligible applicants during special enrollment periods is guaranteed, subject to a pre-existing conditions limitation.

### Worker's Compensation

Policies issued by the Casualty Reciprocal Exchange, a member of the Dodson Insurance group, are administered under the Dodson Savings Plan. Specific aspects include the following:

- \* return declared at the end of each premium year on the basis of loss experience—savings are returned to policyholders
- \* rates standard and approved for class of employment
- \* savings paid as earned within approximately 90 days of policy expiration or on completion of payroll audits

### Accidental Death and Dismemberment

An accidental death and dismemberment plan is underwritten by the Hartford Accident & Indemnity Company. It provides coverage:

- \* for members, their spouses, children and employees
- \* a 24-hour business and pleasure coverage from \$25,000 to \$250,000
- \* renewable to age 70

### Estate Planning

Corroon & Black of Illinois, Inc., offers estate planning services. These include:

- \* educational programs for county society meetings
- \* individual counseling



# Ancillary Organizations

## Illinois State Medical Society Auxiliary

The Illinois State Medical Society Auxiliary is a unique organization composed entirely of physicians' spouses who give their time and talents to promote health awareness, medical legislation and funds for medical research and education (AMA-ERF).

The Illinois State Medical Society Auxiliary had its inception in the parlor car of a speeding train in 1927. Dr. and Mrs. G. Henry Mundt were returning from the AMA meeting in Washington, D.C. and had learned of the existence of the AMA Auxiliary and of 22 functioning state auxiliaries. Mrs. Mundt was persuaded to undertake the task of organizing an auxiliary in Illinois and to seek the approval of the Illinois State Medical Society's House of Delegates. On May 31, 1927, the ISMS House of Delegates endorsed the organization of an auxiliary in Illinois and urged the county societies to assist in promoting auxiliary membership.

The first formal meeting of the Auxiliary was held at the LeClaire Hotel in Moline on June 2, 1927 with 25 members present. In 1928, the organization became permanent. Today, we have a membership of over 3400 and can look with pride on the auxiliary's accomplishments.

The auxiliary has instituted a large number of successful community health programs (e.g., Vial of Life, Nutrition, Physical Fitness, Stress Management, Child Seat Belt Safety, Immunization). We have striven to educate the public on cost effective use of the medical care system and we have been highly successful in fund raising to provide financial assistance to medical students and medical schools (AMA-ERF).

Although we can look with pride upon what we have done, there is much that remains to be accomplished. For example, we will be increasing our fund-raising activities for medical education and research (AMA-ERF). Volunteer organizations such as ours will be assuming a primary role in dealing with society's health problems. We must work to convince other physician spouses that participating in Auxiliary activities is a worthwhile investment of time. Greater involvement with spouses of medical students and residents is encouraged through the SASII program (Sponsor A Spouse In Illinois). On the legislative scene, we provide information on health-related legislation, are a part of a legislative alert system and engage in face-to-face contact with legislators.

We recognize that it is our responsibility to provide leadership education for our up and coming county, state and national leaders. Thus, the inception of the State Leadership Seminars and participation in the AMA Auxiliary Confluence in October for county presidents-elect. We use our "PULSE"

publication to communicate with the membership.

We are also concentrating our efforts on a closer working relationship with ISMS, as together, we meet the challenges of medicine in the '80's.

### OFFICERS

President .....	Mrs. Donald Hinderliter, Rochelle
President-Elect .....	Mrs. Robert Webb, Edwardsville
1st Vice President (Membership Coordinator) .....	Mrs. Robert Reardon, Bloomington
2nd Vice-President (Program and Project Bank Coordinator) .....	Mrs. Selig Hodes, Forreston
3rd Vice-President (Health Projects Coordinator) .....	Mrs. Wayne Kassel, Joliet
Secretary .....	Mrs. L. P. Johnson, Rockford
Treasurer .....	Mrs. Julian Buser, Belleville

### DIRECTORS

Mrs. Harold Keegan, Kankakee  
Mrs. Fred Nathan, Rockford

### PARLIAMENTARIAN

Mrs. Harlan Failor, Champaign

### DISTRICT COUNCILORS

1. Mrs. Charles VanGorder, Geneva
2. Mrs. James Wilson, Princeton
3. Mrs. Morris Friedell, Chicago
4. Mrs. John McLean, Peoria
5. Mrs. Wesley Betsill, Springfield
6. Mrs. Norman Taylor, Rosewood Heights
7. Mrs. Paul Stanley, Decatur
8. Mrs. Mack Hollowell, Charleston
9. Mrs. Gerald Fox, Mt. Vernon
10. Mrs. Stuart Mauch, Jr., Belleville
11. Mrs. August Martinucci, Joliet
12. Mrs. Louis Tisovec, Rockford

## COMMITTEE CHAIRMEN

AMA-ERF ..... Mrs. Karl Reddies, Freeport  
 Archives ..... Mrs. J. D. Winterhalter, Jacksonville  
 Benevolence ..... Mrs. Louis Tarsinos, Princeton  
 Bylaws ..... Mrs. Harlan Failor, Champaign  
 Convention ..... Mrs. R. Samuel Hoover, Lake Forest  
 Editor ..... Mrs. Philip Hays, Kankakee  
 Fall Conference ..... Mrs. John Krueger, Normal  
 Finance ..... Mrs. William Hodges, Kankakee  
 Health Projects  
 Coordinator ..... Mrs. Wayne Kassel, Joliet  
 Child Seat  
 Belt Safety ..... Mrs. Ronald Severino, Wheaton  
 Cult Awareness ..... Mrs. George Olander, Lake Forest  
 Exceptional Person  
 Awareness ..... Mrs. Gene Hoerr, Peoria  
 Smoking & Disease ..... Mrs. John Simonaitis, Elmhurst  
 Grief &  
 Bereavement ..... Mrs. Donald Fisk, Galesburg  
 Health Awareness ..... Mrs. Francisco Juco, Peoria  
 Health Education ..... Mrs. Edward Kwedar, Springfield  
 Mental Health  
 & Fitness ..... Mrs. Alex Spadoni, Hinsdale  
 Hospitality ..... Mrs. Eugene Leonard, Rockford  
 Humanitarian Award ..... Mrs. Gustavo Bermudez, Chicago  
 Leadership Seminar  
 Coordinator ..... Mrs. John Peterson, Jacksonville  
 Legislation Coordinator ..... Mrs. Alan Taylor, Danville  
 Long Range Planning ..... Mrs. Robert Webb, Edwardsville  
 Membership  
 Coordinator ..... Mrs. Robert Reardon, Bloomington  
 Members-at-Large ..... Mrs. Thomas Meirink, Belleville

Program & Project Bank ..... Mrs. Selig Hodes, Forreston  
 Public Relations ..... Mrs. Terry Arnold, Quincy  
 Transition into  
 Practice Program ..... Mrs. Ronald Welch, Freeburg  
 55 Years of  
 Auxiliary ..... Mrs. Eugene Vickery, Lena

## REPRESENTATIVES TO ISMS COUNCILS AND COMMITTEES

Benevolence ..... Mrs. Louis Tarsinos, Princeton  
 Governmental Affairs ..... Mrs. Alan Taylor, Danville  
 Mental Health and  
 Addiction ..... Mrs. Alex Spadoni, Hinsdale  
 Public Relations and  
 Membership  
 Services ..... Mrs. Robert Reardon, Bloomington  
 Social and  
 Medical Services ..... Mrs. Selig Hodes, Forreston  
 Alcoholism and  
 Drug Dependence ..... Mrs. Donald Hinderliter, Rochelle  
 Health Planning ..... Mrs. Harlan Failor, Champaign  
 Sports Medicine ..... Mrs. Harold Keegan, Kankakee

## REPRESENTATIVES TO OUTSIDE GROUPS

Illinois Interagency Council  
 on Smoking & Disease ..... Mrs. John Simonaitis, Elmhurst  
 INA-ISMS Joint Practice  
 Committee ..... Mrs. Larry Schick, Rockford

# American Association of Medical Assistants, Illinois Society

The American Association of Medical Assistants is a national, non-profit organization dedicated to the professional advancement of medical assistants. This tri-level structure—similar to AMA—encompasses local, state and national affiliation.

Membership in the Illinois Society, AAMA, is open to medical assistants, office nurses, technicians, secretaries, bookkeepers and clerks performing administrative and/or clinical duties under the direct supervision of a physician. College students attending medical assistant programs are encouraged to belong. Physician advisors at all three levels assist with educational endeavors.

The state society's numerous professional, educational programs in various parts of the state offer continuing education units (CEU) to its participants. Some of the major programs are: travel course, regional seminars, annual symposium, personal development day and the all day workshop held in conjunction with Chicago Medical Society's Midwest Clinical Conference. The annual three day meeting in April includes excellent lectures, study programs and the culmination of association business during the House of Delegates Session.

The American Association of Medical Assistants encourages

advancement of medical assistants by offering a certification examination designed to evaluate professional competency. Local chapters, in addition to their regularly scheduled monthly educational programs, conduct preparatory classes in terminology, physiology, anatomy, human relations, patient contact, medical law and ethics, communications, bookkeeping, insurance, administrative procedures, laboratory orientation and collection methods. The certification examination is administered twice a year.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully passing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants. Specialty examinations are given in Administrative, Clinical and Pediatric divisions. For further information about this program contact the American Association of Medical Assistants, One East Wacker Drive, Chicago, Illinois 60601.

Members interested in independent continuing education through a "home study" program may purchase and utilize audio cassettes and workbooks. The president of the Illinois Society communicates, via the "Executive Memo" (a monthly publication), with over 500 members giving pertinent infor-



mation of current activities.

A quarterly publication "The Illini Cardinal" concentrates on educational topics and is available to all members without additional cost. "The Professional Medical Assistant," the official bi-monthly journal of the association, is largely devoted to original articles written for medical assistants by their peers or other professionals in related fields. It is an automatic benefit of membership, although subscriptions are available for non-members. There are many other benefits available (*i.e.* group insurance). During the Annual Meeting of AAMA each fall, a variety of experts in medical and related fields address participants during educational programs and workshops.

Monthly educational meetings are scheduled in the following chapters: Cook County-Chicago (Downtown), Southwest Suburban (Oak Lawn), Northwest (Arlington Heights), West Cook (River Grove), Cook County South (Oak Forest), Aux Plaines (Oak Park), DuPage (Wheaton), Coles-Cumberland (Charleston), DeKalb (Sycamore), LaSalle, Macon (Decatur), McLean (Bloomington), Peoria, Randolph (Chester), Rock Island-Moline, St. Clair (Belleville), Spoon River Valley (Canton), Vermilion (Danville), Will Grundy (Joliet) and Winnebago (Rockford). Physicians in these areas are asked to encourage their medical assistants to join the association and actively participate in the selection of educational programs that will enable the members to become better medical assistants.

For membership information please contact: Janet Binkowski, R.N., President, 428 Adams St., Dolton, IL 60419 or Mary Lu Ostrowski, CMA, 1704 E. Jackson St., Bloom-

ington, IL 61701

## OFFICERS

President: Janet Binkowski, R.N., Dolton  
 President Elect: Betty Kronmeyer, CMA, Mascoutah  
 Immediate Past President: Mary Lu Ostrowski, CMA, Bloomington  
 1st Vice President: Ehlma Garcia, CMA, Chicago  
 2nd Vice President: Shirley Fox, Sparta  
 Recording Secretary: Cheryl Smiley, CMA, Westville  
 Membership Secretary: Sandra Yenerich, R.N., Homewood  
 Corresponding Secretary: Jean Berschinski, Homewood  
 Treasurer: Dolores Dupree, Berwyn  
 Speaker of the House: Luella Mitchell, CMA, Chicago  
 Vice Speaker of the House: Pauline Klarich, Peoria  
 Board of Trustees, Chairman: Leslie Lee, Chicago  
 Parliamentary Advisor: Ruby Jackson, CMA, Chicago  
 Chaplain: Darlene Van Dyke, Westchester  
 Historian: Jackie Chesley, CMA-C, Evergreen Park

## Physician Advisors

John L. Wright, M.D., Bloomington, *Chairman*  
 Thomas R. Harwood, M.D., Chicago  
 Peter C. Lee, M.D., Granite City  
 Leslie Schwartz, M.D., Chicago  
 Robert R. Hartman, M.D., Jacksonville, *Liaison to ISMS*  
 Robert E. Thompson, M.D., Peoria  
 Allison Burdick, Sr., M.D., Chicago, *Emeritus Member*

# The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

- 1) The initiation of scientific and medical research activities.
- 2) The collection, evaluation and dissemination of the results of research activities to the public.
- 3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It

is staffed through ISMS headquarters.

The ISMS immediate past president serves as chairman of the Foundation's Board of Directors.

## Board of Directors

Fred Z. White, Chillicothe, *Chairman*  
 Jere Freidheim, Chicago  
 Robert P. Johnson, Springfield  
 Warren D. Tuttle, Harrisburg  
 Cyril C. Wiggishoff, Chicago

# Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in co-operation with the state's eight medical schools, to fulfill these purposes: (a) encourage and assist in the development of continuing medical education programs for Illinois physicians that will enhance patient care; (b) study and encourage development of new educational methods, techniques, systems, *etc.*; (c) assist learning sources to identify the educational needs of Illinois physicians; and (d) stimulate, motivate, and encourage physicians at all levels throughout the state to participate in formal continuing educational programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as President of ISMS. Following careful study, the 1970 House of Delegates approved the plan in principle. The next President, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as Chairman of the Organizing Committee.

ICCME was officially chartered by the state as a nonprofit educational organization in May, 1972, and began operations in September, 1972. Financial support of the Council is provided primarily by ISMS members' dues.

ICCME unites the resources of the Illinois State Medical Society and the educational resources of the state's medical schools; it serves *all* interests concerned with CME and thus provides a crucial channel of communication to co-ordinate the efficient use of all available resources.

#### Current Major Activities

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois health-care system in the Council's work. The tenth Annual Congress will meet in 1982.
2. On behalf of ISMS, perform site visits for accreditation of intrastate CME including advice on preparing to apply for accreditation.
3. Advise hospitals and other organizations on effective CME planning and organization.
4. Organize workshops on techniques of CME—including an unusual "Seminar on CME Leadership" for leaders of hospital medical staffs and medical societies.
5. Develop and publish CME planning aids that offer practical advice and important background on effective organization of CME. Included are *Your Personal Learning Plan*, a unique handbook offering advice on how to plan

your learning most effectively; and *How to Start a CME Program in Your Hospital or Medical Society* for CME planners. For all items now available, request "The Illinois Handbook on CME Planning—Catalog/Order Form." All publications are available to ISMS members at a 50% discount. To obtain a copy of the Catalog/Order Form just indicate this on your prescription form and mail to ICCME, 55 E. Monroe, Chicago, IL 60603.

6. Prepare a monthly calendar of Illinois CME activities for *IMJ*.
7. Plan and conduct research studies that contribute to the improvement of CME methods.

#### Organization & Governance

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of: nine practicing physicians representing the State Medical Society; and eight academic physicians/educators, one selected by each dean of an Illinois medical school.

### Board of Directors\*

Donald F. Pochly, M.D., M.Ed., Hines, *President*  
 Harold A. Paul, M.D., M.P.H., Chicago, *Vice-President*  
 Dean R. Bérdeaux, M.D., M.A.(Educ.), Peoria, *Treasurer*  
 Charles E. Osborne, Ed.D., Springfield, *Secretary*  
 Robert A. Behmer, Rockford, *Ex Officio*  
 Ben B. Blivaiss, Ph.D., North Chicago  
 Ernst Chester Bone, M.A.(Educ.), M.D., Jacksonville  
 Michael H. M. Dykes, M.D., M.Ed., Chicago  
 Linda K. Gunzburger, Ph.D., Maywood

Lawrence L. Hirsch, North Chicago  
 Kenneth A. Hurst, Naperville  
 Marten M. Kernis, Ph.D., Chicago  
 Alfred J. Kiessel, Decatur, *Ex Officio*  
 Chase P. Kimball, Chicago  
 Ward E. Perrin, D.O., F.A.C.O.I., Chicago  
 Robert L. Prentice, Springfield  
 Fred Z. White, M.D., M.A.(Educ.), Chillicothe, *Liaison*  
 (ICCME Executive Committee)

\*All above are physicians unless otherwise indicated.

### Panel of Accreditation Site Visit Surveyors

Serving as Surveyors are Board Members of the Illinois Council on Continuing Medical Education and others chosen by the ICCME Board who meet criteria adopted by the ISMS Board of Trustees March 31, 1979. ICCME does *not* make accreditation decisions, neither individual Board Members nor the Board collectively. Rather, the Survey Team's role is analogous to that of the physician who performs a physical examination on a potential purchaser of life insurance: to

ascertain and report the facts, leaving to the underwriter the actuarial decision on granting insurance. The Survey Team makes a judgment on each of the seven "Illinois Criteria," on the basis of point values prescribed by the ISMS Committee on CME Accreditation, as well as the Team's conversation with the Sponsor. Individuals serving on the Panel of Surveyors, in addition to members of the ICCME Board, are (all are physicians unless otherwise indicated):

Philip D. Anderson, M.D., Ph.D.  
 Lloyd Barr, Ph.D.  
 Bradford W. Claxton, M.Ed.  
 Anthony L. Barbato  
 Alfred J. Clementi  
 Joseph L. Daddino  
 John G. Demakis  
 Richard E. Dukes  
 Sherman Elias  
 L. Penfield Faber  
 Charles G. Farnum, Jr.  
 Peter O. Fried  
 Allan L. Goslin  
 Robert C. Hamilton  
 Robert R. Hartman

Henri S. Havdala  
 Thomas O. Henderson, Ph.D.  
 Eugene T. Hoban  
 John M. Holland  
 Kathryn S. Huss  
 Ross N. Hutchison  
 William L. Jackson  
 Harold L. Jensen  
 Frank J. Jirka, Jr.  
 Eugene P. Johnson  
 James M. Laidlaw  
 Howard B. Levy  
 Paul A. Maxwell, Jr.  
 Boyd E. McCracken, Sr.  
 Morgan M. Meyer

Julius S. Newman  
 Joseph R. O'Donnell  
 Joseph B. Perez  
 Mather Pfeifferberger  
 Eugene Scherba  
 Joseph C. Sherrick  
 George Shropshear  
 Robert C. Stepto  
 Jacob R. Suker  
 L. W. Tanner  
 Sheldon S. Waldstein  
 Charles J. Weigel  
 George T. Wilkins  
 Roger A. Wujek



## Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care (IFMC) is a not-for-profit corporation established in 1971 by action of the House of Delegates. Under revised bylaws adopted June, 1977, IFMC is operated under direction of a 6-member Board of Directors elected annually by the ISMS Board of Trustees. The IFMC currently contracts with the Regional Health Resources Center, Urbana, Illinois for administrative services.

IFMC maintains relationships with several local foundations for medical care and is available to serve their needs on a cost reimbursement basis.

### IFMC Board of Directors

Joseph Sherrick, Chicago, *President*  
Robert P. Johnson, Springfield, *Vice-President*  
James Laidlaw, Champaign, *Secretary-Treasurer*  
Audley F. Connor, Chicago  
Morris T. Friedell, Chicago  
Lawrence L. Hirsch, Chicago  
Robert Prentice, Springfield

## Illinois State Medical Society Political Action Committee (IMPAC)

The Illinois State Medical Society Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their spouses. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his spouse can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Congress.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, 55 E. Monroe, Suite 3510, Chicago 60603.

## Illinois State Medical Insurance Services, Inc.

Illinois State Medical Insurance Services is an Illinois corporation, formed in March, 1976, all of whose capital stock is owned by the Illinois State Medical Society. Its sole business is to act as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

The Exchange was organized to provide comprehensive professional liability insurance for Illinois physicians. Its membership is limited to members of the Illinois State Medical Society.

Insurance Services provides all the management and underwriting services required for the operation of the insurance business of the Exchange. It does so under Power-of-Attorney granted it by the Exchange in a management agreement and by each member of the Exchange through his application for membership. Under the management agreement the Board of Governors of the Exchange prescribes policy to be followed in the conduct of the business; within the guidelines established by these policy statements, Insurance Services manages the business of the Exchange, accepting or rejecting applications, determining the form of insurance policies, handling and disposing of claims, and performing all related functions. Insurance Services is compensated by the Exchange on the basis of expense reimbursement; it is not anticipated that Insurance Services will produce any operating profit.

The organization of Insurance Services comprises three

principal functional divisions: Underwriting and Risk Management, Claims, and Administrative Services. Advisory and consultative services are provided by member physicians through a review system organized and directed by the Medical Director of Insurance Services. Financial and accounting services are provided by staff of the Illinois State Medical Society, whose Director of Finance serves as Controller of Insurance Services. The offices of Illinois State Medical Insurance Services, Inc., are at 55 East Monroe Street, Suite 3440, Chicago, Illinois 60603.

### Board of Directors

Phillip D. Boren, M.D.  
Alfred Clementi, M.D.  
Robert Hamilton, M.D.  
J. M. Ingalls, M.D.  
Clifton L. Reeder, M.D.  
Warren D. Tuttle, M.D.

### Officers

Clifton L. Reeder, M.D., *Chairman*  
Paul E. Singer, *President*  
Henry Nussbaum, *Vice President*  
Alexander R. Lerner, *Secretary-Treasurer*  
Clinton L. Compere, M.D., *Medical Director*

## Resident Physicians Section

Brad Epstein, *Chairman*  
David Palmer, *Vice-Chairman*  
Raymond Maciejewski, *Secretary/Treasurer*  
David Whitney, *Delegate*  
Michael Nieder, *Alternate Delegate*

### Council Representatives

Frank Pieri, *Medical-Legal Council*  
James Meserow, *Public Relations & Membership Services*  
John Diveris, *Council on Education & Manpower*  
Janice E. Polk, *Council on Mental Health & Addiction*  
Nicholas Schlageter, *Council on Governmental Affairs*

Michael Reiermaier, *Council on Medical Services*  
Ray Maciejewski, *Council on Economics*

### Responsibilities and Purposes

The purposes of the Resident Physicians Section shall be to encourage and support the active participation of physicians in training in the Illinois State Medical Society and to provide representation of intern-resident opinions and ideas in organized medicine. In addition, the Resident Physicians Section shall support the purposes of the ISMS, as stated in its Constitution. All in-training members of the ISMS shall be members of the Resident Physicians Section, having the right to vote and hold office.

## Medical Student Section

Kurt Elward, *Chairman*  
Linda Tetzlaff, *Vice Chairman*  
Don Matsunaga, *Secretary*  
Malcolm Major, *Delegate*  
Patrick J. Merrill, *Alternate Delegate*  
James Glauber, *MECO Coordinator*

### School Representatives

Chicago Medical School  
Mark Trankina  
Loyola University  
Richard N. Olen  
Northwestern University  
Dirk Proffer  
Rush Medical College  
Tammy Kaplan  
Southern Illinois University—Springfield  
Linda Hippenhammer  
Southern Illinois University—Carbondale  
Robert N. Hetz  
University of Chicago  
Joseph Hughes  
University of Illinois—Chicago  
George Beranek  
University of Illinois—Champaign/Urbana  
Patrick J. Merrill

University of Illinois—Peoria  
Don Matsunaga  
University of Illinois—Rockford  
Janet Schmidt  
Chicago College of Osteopathic Medicine  
John Dolehide

### Council Representatives

Paula M. Olen, *Council on Education & Manpower*  
Crystal Cash, *Council on Public Relations & Membership Services*  
Mark Donvito, *Council on Medical Services*  
Gail D. Williamson, *Council on Economics*  
James P. Kelly, *Medical-Legal Council*  
Dana Brazdziunas, *Council on Mental Health & Addiction*  
Ronald M. Davis, *Governmental Affairs Council*

### Responsibilities and Purposes

The purposes of the Medical Student Section shall be to encourage and support the active participation of medical students in the ISMS and to provide a representation of student opinions and ideals in organized medicine. In addition, the Medical Student Section shall support the purposes of ISMS as stated in its Constitution. The Medical Student Section is composed of all student members of ISMS.

## MEDICAL AND ALLIED HEALTH EDUCATION

### MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

University of the Health Sciences/The Chicago Medical School  
3333 Green Bay Road, North Chicago, IL 60064  
Northwestern University Medical School  
303 E. Chicago Ave., Chicago, 60611  
University of Chicago-Pritzker School of Medicine  
950 E. 59th Street, Chicago, 60637  
University of Illinois College of Medicine\*  
Chicago Campus—  
1853 W. Polk Street, Chicago, 60612

Loyola University, Stritch School of Medicine  
2160 S. First Ave., Maywood, 60153  
Rush Medical College  
1725 W. Harrison St., Chicago, 60612  
Southern Illinois University School of Medicine  
801 N. Rutledge, P.O. Box 3926, Springfield, 62708

\*Note: This is the parent college for Abraham Lincoln School of Medicine, Peoria School of Medicine, Rockford School of Medicine and the School of Basic Medical Sciences (Urbana).



## ALLIED HEALTH EDUCATIONAL PROGRAMS

Accredited by the American Medical Association Committee on  
Allied Health Education and Accreditation

### CYTOTECHNOLOGIST

CHICAGO—Michael Reese Hospital & Medical Center  
Mount Sinai Hospital Medical Center  
University of Chicago—Lying-in-Hospital

### HISTOLOGIC TECHNICIAN

CHICAGO—Holy Cross Hospital  
Mercy Hospital & Medical Center  
Mount Sinai Hospital & Medical Center  
St. Joseph Hospital  
University of Chicago Hospitals & Clinics  
PEORIA—St. Francis Hospital and Medical Center  
Methodist Medical Center of Illinois  
SPRINGFIELD—Memorial Medical Center  
St. John's Hospital

### MEDICAL ASSISTANTS

BELLEVILLE—Belleville Area College  
CARTHAGE—Robert Morris College  
PALATINE—William Rainey Harper College  
RIVER GROVE—Triton College

### MEDICAL LABORATORY TECHNICIAN

BELLEVILLE—Belleville Area College  
CHICAGO—Malcolm X College  
DES PLAINES—Oakton Community College  
DIXON—Sauk Valley College  
EAST PEORIA—Illinois Central College  
ELGIN—Sherman Hospital Association  
GODFREY—Lewis & Clark Community College  
GRAYS LAKE—College of Lake County  
KANKAKEE—Kankakee Community College  
MORTON GROVE—Oakton Community College  
PALOS HILLS—Moraine Valley Community College  
QUINCY—Blessing Hospital  
RIVER GROVE—Triton College

### MEDICAL RECORD ADMINISTRATORS

CHICAGO—University of Illinois College of Medicine  
Chicago State University  
University of Illinois at the Medical Center  
Campus  
College of Associated Health Professions  
NORMAL—Illinois State University

### MEDICAL RECORD TECHNICIAN

BELLEVILLE—Belleville Area College  
CHICAGO—Central YMCA Community College  
DES PLAINES—Oakton Community College  
GRAYSLAKE—College of Lake County  
PALOS HILLS—Moraine Valley Community College

### MEDICAL TECHNOLOGIST

ARLINGTON HTS.—Northwest Community Hospital  
BELLEVILLE—St. Elizabeth Hospital  
BLUE ISLAND—St. Francis Hospital  
CHAMPAIGN—Burnham City Hospital  
CHICAGO—Holy Cross Hospital  
Illinois Masonic Medical Center  
Louis A. Weiss Memorial Hospital  
Northwestern University Medical School  
Michael Reese Hospital & Medical Center  
Rush-Presbyterian-St. Luke's Medical Center  
St. Anne's Hospital  
St. Joseph Hospital  
St. Mary of Nazareth Hospital Center  
University of Illinois College of Medicine  
DANVILLE—Lakeview Medical Center  
DECATUR—Decatur Memorial Hospital  
St. Mary's Hospital  
EVANSTON—Evanston Hospital  
FREEPORT—Freeport Memorial Hospital  
HINES—Edward Hines Jr. V.A. Hospital  
HINSDALE—Hinsdale Sanitarium & Hospital  
JOLIET—St. Joseph Hospital  
Silver Cross Hospital  
MAYWOOD—Foster G. McGaw Hosp./Loyola University  
NORTH CHICAGO—University of Health Sciences/  
Chicago Medical School  
OAK LAWN—Christ Hospital  
OAK PARK—West Suburban Hospital Association  
PARK FOREST—Governors State University  
PARK RIDGE—Lutheran General Hospital  
PEORIA—Methodist Medical Center of Central Illinois  
St. Francis Hospital and Medical Center  
QUINCY—St. Mary's Hospital  
ROCKFORD—Rockford Memorial Hospital  
St. Anthony Hospital and Medical Center  
SwedishAmerican Hospital  
SPRINGFIELD—St. John's Hospital  
Sangamon State University  
URBANA—Carle Foundation Hospital  
WAUKEGAN—St. Therese Hospital  
WINFIELD—Central DuPage Hospital

### NUCLEAR MEDICINE TECHNOLOGY

CHICAGO—Illinois Masonic Medical Center  
Northwestern Memorial Hospital  
HINES—V. A. Hospital  
PEORIA—St. Francis Hospital-Medical Center  
RIVER GROVE—Triton College

### OCCUPATIONAL THERAPIST

CHICAGO—University of Illinois College of Medicine

## PHYSICAL THERAPIST

CHICAGO—Northwestern University  
University of Illinois College of Medicine  
NORTH CHICAGO—University of Health Sciences/  
Chicago Medical School

## RADIOGRAPHER

ARLINGTON HTS.—Northwest Community Hospital  
BELLEVILLE—Belleville Area College  
CARBONDALE—Southern Illinois University  
CENTRALIA—Kaskaskia College  
CHAMPAIGN—Parkland College  
CHICAGO—Central YMCA Community College  
Cook County Hospital  
DePaul University  
Henrotin Hospital  
Illinois Masonic Medical Center  
Malcolm X College  
Provident Hospital & Training School  
Ravenswood Hospital Medical Center  
St. Anne's Hospital  
St. Joseph Hospital  
South Chicago Community Hospital  
University of Illinois Hospital  
Wilbur Wright College

DANVILLE—Lake View Medical Center  
DECATUR—Decatur Memorial Hospital  
DES PLAINES—Oakton Community College  
DIXON—Sauk Valley College  
EAST PEORIA—Illinois Central College  
ELGIN—St. Joseph Hospital  
EVANSTON—St. Francis Hospital  
GALESBURG—Carl Sandburg College  
GLEN ELLYN—College of DuPage  
GRAYSLAKE—College of Lake County  
HINSDALE—Hinsdale Sanitarium & Hospital  
KANKAKEE—Kankakee Community College  
KEWANEE—Kewanee Public Hospital  
MACOMB—McDonough District Hospital  
MALTA—Kishwaukee College  
MOLINE—Black Hawk College  
Moline Public Hospital  
NORMAL—Brokaw Hospital  
OLNEY—Richland Memorial Hospital  
PALOS HILLS—Moraine Valley Community College  
PEORIA—St. Francis Hospital Med. Center  
QUINCY—Blessing Hospital  
St. Mary's Hospital  
RIVER GROVE—Triton College  
ROCKFORD—Rockford Memorial Hospital  
SwedishAmerican Hospital  
ROCK ISLAND—Rock Island Franciscan Hospital  
SOUTH HOLLAND—Thornton Community College  
SPRINGFIELD—Lincoln Land Community College  
Memorial Medical Center

## RESPIRATORY THERAPIST

CHAMPAIGN—Parkland College  
CHICAGO—Central YMCA Community College  
Malcolm X College  
Northwestern University  
University of Chicago Hospitals & Clinics  
MOLINE—Black Hawk College  
PALOS HILLS—Moraine Valley Community College  
RIVER GROVE—Triton College  
ROCKFORD—Rock Valley College  
SPRINGFIELD—Lincoln Land Community College

## RESPIRATORY THERAPY TECHNICIAN

BELLEVILLE—Belleville Area Jr. College  
CHAMPAIGN—Parkland College  
CHICAGO—Metropolitan Group of Hospitals  
Northwestern Memorial Hospital  
South Chicago Community Hospital  
University of Chicago Hospitals and Clinics  
GLEN ELLYN—College of DuPage  
KANKAKEE—Kankakee Community College  
MOLINE—Black Hawk College  
OAK LAWN—Christ Hospital  
PALOS HILLS—Moraine Valley Community College  
QUINCY—St. Mary's Hospital  
ROCKFORD—SwedishAmerican Hospital  
ROCKFORD—Rock Valley College  
SPRINGFIELD—St. John's Hospital  
WAUKEGAN—Victory Memorial Hospital

## RADIATION THERAPY TECHNOLOGIST

CHICAGO—Chicago State University  
Michael Reese Hospital/City Wide College  
ELGIN—St. Joseph Hospital  
EVANSTON—National College of Education  
St. Francis Hospital  
HINES—V. A. Hospital  
ROCKFORD—SwedishAmerican Hospital

## SPECIALIST IN BLOOD BANK TECHNOLOGY

CHICAGO—Michael Reese Blood Center  
Mid-Amer RC Blood Svcs/C. Hymen Blood Center  
University of Illinois College of Medicine  
PARK RIDGE—Lutheran General Hospital

## SURGICAL TECHNOLOGIST

BELLEVILLE—Belleville Area College  
CENTRALIA—Kaskaskia Junior College  
CHAMPAIGN—Parkland College  
EAST PEORIA—Illinois Central College  
MOLINE—Moline Public Hospital  
PALOS HILLS—Moraine Valley Community College  
QUINCY—Blessing Hospital  
RIVER GROVE—Triton College



# ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

Election of senators and representatives is determined in the apportioned districts throughout the state. One senator is elected from each of the 59 districts. As provided by a recent amendment to the Illinois Constitution, representatives are now also elected from single member districts of which there are 118.

The General Assembly convenes each year on the second Wednesday of January. The General Assembly is a continuous body during the two year term for which members of the

House of Representatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. The committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

## EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for

four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They are elected every four years.

## STATE OFFICERS 1982

*Governor*, JAMES R. THOMPSON, Rep., Chicago  
*Lieutenant Governor*, Vacant  
*Secretary of State*, JIM EDGAR, Rep., Charleston  
*Comptroller*, ROLAND W. BURRIS, Dem., Chicago

*Treasurer*, JEROME COSENTINO, Dem., Palos Heights  
*Attorney General*, TYRONE FAHNER, Rep., Evanston  
*Clerk of the Supreme Court*, JULEANN HORNYAK, Springfield

## LEGISLATIVE BRANCH

### Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading after which it is acted upon by the entire membership of the house that is considering it.

### Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (60 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be

appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the governor for his consideration.

If the governor thinks the bill should become a law, he will sign it. If the governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each House can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The governor may also return a bill to the Legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

### Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available at no cost to ISMS members. Requests should be directed to: Illinois State Medical Society, Regional Office, 701 S. Second St., Springfield 62704.

## **DANGEROUS DRUGS COMMISSION**

300 N. State Street, Chicago 60610, Phone: 312/822-9860  
 300 W. Monroe Street, Springfield 62706, Phone: 217/782-0685  
 Thomas B. Kirkpatrick, Jr., Executive Director

The Dangerous Drugs Commission is the single state agency responsible for all drug abuse treatment and prevention in Illinois, and for the preparation of all drug abuse planning and allocation of state and federal drug abuse funds. Other responsibilities include scheduling of controlled substances, licensing of drug abuse programs and controlled substances research, and training.

### **Administrative Staff**

Daniel W. Behnke, Deputy Director

Barbara Frazin-Weiner, Chief Counsel  
 Patricia J. Larsen, Special Assistant to the Director  
 Linda Hargnett, Administrator, Planning and Program Development  
 Krishan Kaistha, Ph.D., Chief Toxicologist  
 Edward Duffy, Administrator, Management  
 Felix Matlock, Administrator, Field Operations  
 Neil A. Reilly, Administrator, Compliance and Enforcement

## **STATUTORY BODIES**

### **Dangerous Drugs Commission**

Ivan Pavkovic, M.D., Chicago, *Chairman*  
 Gregory L. Coler, Springfield  
 Donald Gill, Springfield  
 Robert Granzeier, Springfield  
 William Kempiners, Springfield  
 Michael Lane, Springfield  
 Jeffrey Miller, Chicago  
 Robin Morgenstern, Chicago  
 Joseph Skom, M.D., Chicago  
 James Zagel, Chicago

### **Dangerous Drugs Advisory Council**

Rep. L. Michael Getty, Dolton, *Chairman*  
 Mrs. Roalda J. Alderman, Chicago  
 David Bingaman, Oak Park  
 Peg Blaser, Springfield  
 David Blumenfeld, Esq., Chicago  
 Supt. Richard Brzeczek, Chicago  
 Gary Clayton, Springfield  
 Richard M. Daley, Esq., Chicago  
 Sen. John D'Arco, Chicago

Sheriff Richard Doria, Wheaton  
 Ronald Dozier, Esq., Bloomington  
 Rep. John F. Dunn, Decatur  
 Sen. Forest Etheredge, Aurora  
 Marian Fiske, R.N., Chicago  
 Norman Garfinkel, R.Ph., Oak Park  
 Rep. George Hudson, Hinsdale  
 Hal Ross Kessler, Chicago  
 Hon. Benjamin S. Mackoff, Chicago  
 Hugo Muriel, M.D., Chicago  
 Sen. Dawn Clark Netsch, Chicago  
 Billie Paige, Oak Brook  
 Don Paull, Ph.D., Chicago  
 Harry Sholl, Lake Forest  
 Donna Simonson, Springfield  
 Rep. Roger Stanley, Streamwood  
 Sen. Randy Thomas, Moline  
 Vacancy—Illinois State Dental Society  
 Robert B. Uretz, Ph.D., Chicago  
 Ted Weslowski, Chicago  
 Hon. Daniel White, Chicago  
 Cyril C. Wiggishoff, M.D., Chicago

## **DEPARTMENT OF CHILDREN AND FAMILY SERVICES**

160 North LaSalle Street, Room 1700, Chicago 60601  
 One North Old State Capitol Plaza, Springfield 62706  
 Gregory L. Coler, *Director*

### **Director's Office**

Iris Slack, Deputy Director for Policy and Plans  
 Gordon Johnson, Deputy Director for Program Operations  
 Thomas Walsh, Deputy Director for Management and Budget  
 Michael Tristano, Deputy Director for Child Protection  
 Peter Digre, Deputy Director for Youth and Community Services  
 Donald H. Schlosser, Chief of Communication/Community Relations  
 Marian Barnes, Chief Legal Counsel  
 Bruce Rubenstein, Legislative Liaison  
 Maurice Graham, Chief of Internal Audits  
 Paul Freedlund, Special Assistant to the Director

### **Regional Offices**

John Robinson, Region 1A Administrator, Rockford

Thomas Ward, Region 1B Administrator, Peoria  
 Les Townsend, Region 2A Administrator, Aurora  
 Gordon Johnson, Region 2B Administrator, Chicago  
 William Gillespie, Region 3A Administrator, Springfield  
 Willis Hartman, Region 3B Administrator, Champaign  
 Anthony Jenkins, Region 4 Administrator, East St. Louis  
 Gene Ruehmkorff, Region 5 Administrator, Marion

### **Advisory Councils**

DCFS Advisory Council, John Madden, Chairperson  
 Statewide Citizen's Committee on Child Abuse and Neglect,  
 Nancy Peterson, Chairperson  
 Statewide Day Care Advisory Committee, Mae Husband,  
 Chairperson



## DEPARTMENT OF CORRECTIONS

160 N. LaSalle  
Chicago, IL 60601  
(312) 793-2955  
1301 Concordia Court  
Springfield, IL 62702  
(217) 522-2666  
Michael P. Lane, *Director*

Leo L. Meyer, Deputy Director-Adult Institutions  
James R. Irving, Deputy Director-Juvenile Division  
Anthony M. Scillia, Deputy Director-Community Services  
J. Thomas Hutchison, Deputy Director-Bureau of Administrative Services  
Dr. William H. Craine, Deputy Director-Bureau of Employee and Inmate Services  
Robert H. Klemm, Deputy Director-Bureau of Inspections and Audits  
John Dreiske, Deputy Director-Bureau of Policy Development  
Samuel J. Sublett, Accreditation Manager  
Nic Howell, Public Information Officer  
Dr. Ronald Shansky, Medical Director

*Programs:* 1) To develop and maintain reception and evaluation units for the purpose of analyzing the custody and rehabilitation needs of juvenile and adult offenders committed to it and to assign such persons to institutions and programs under its control or transfer them to other appropriate agencies; 2) to develop and maintain programs of control, rehabilitation and employment of committed persons within its institutions; 3) to establish a system of release, supervision and guidance of committed persons in the community; 4) to maintain records of persons committed to it and to establish programs of research, statistics and planning; 5) to investigate the grievances of any person committed to the agency and to inquire into any alleged misconduct by employees; and 6) to cooperate with other departments and agencies and with local communities for the development of standards and programs for better correctional services within the State.

## DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

401 S. Spring St., Springfield, 62706  
160 N. La Salle St., Chicago, 60601  
Ivan Pavkovic, M.D., *Director*  
Roalda J. Alderman, Associate Director for Alcoholism  
Patricia Barger, Ph.D., Associate Director for Mental Illness  
Richard Blanton, Ph.D., Associate Director for Developmental Disabilities  
John P. Harcourt, Jr., Associate Director for Support Services

### Office of the Director

Russell Blaauw, Legislative Liaison  
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John Ryan, Special Assistant  
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Harriett Mitchell, Administrative Assistant

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Kenneth R. Swiatek, Ph.D., Illinois Institute for Developmental Disabilities  
Paul Schyve, M.D., (Acting), Illinois State Psychiatric Institute  
Donald W. Hart, Region 1-A Administrator, Rockford  
James Dalzell, Region 1-B Administrator, Peoria  
Barry I. Fireman, Ph.D., J.D., Region 2 Administrator, Chicago  
Ugo Formigoni, Region 3-A Administrator, Springfield  
J. Gregory Langan, Ed.D., Region 3-B Administrator, Champaign  
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Ronald G. Bittle, Ph.D., Region 5 Administrator, Anna

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 Helen Hudlin, Ph.D., E. St. Louis  
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 Maxine Rosenbarger, Ph.D., Carbondale  
 Viola Walker, Centralia

## DEPARTMENT OF PUBLIC AID

316 South 2nd St., Springfield, 62701  
 Jeffrey C. Miller, *Director*

The Illinois Department of Public Aid administers the federally aided public assistance programs: Aid to Families with Dependent Children; Medical Assistance; and provides supplemental financial grants to eligible aged, blind, or disabled persons. In addition, the department allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp program.

### Administrative Staff

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 David L. Daniel, Assistant Director  
 Tim Claborn, Legislative Liaison  
 Johnetta W. Jordan, Chief, Office of Public Information  
 H. Dickson Buckley, Special Assistant to the Director  
 Louis Bosco, Chief, Office of Personnel Management and Labor Relations

Verne H. Evans, Chief, Office of Hearings/Recoveries  
 David Rakov, General Counsel, Office of Counseling/Litigation  
 Daniel McCarthy, Chief Auditor  
 Mary Ann Langston, Policy & Planning Administrator  
 Norman Ryan, General Services Administrator  
 Donna Johnson, Acting Operations Administration Administrator  
 Betsy Skloot, Medical Programs Administrator

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Sen. Jack Schaffer, Cary  
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## DEPARTMENT OF PUBLIC HEALTH

535 West Jefferson St., Springfield 62706

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Robert Hedges, *Legislative Liaison*

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Richard Moy, M.D., Springfield  
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Fred H. Uhlig  
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(Allied with Public Health Operations)

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 Marie Walsh, R.N., Glenview

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### (Allied with Public Health Operations)

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 J. V. Johnson, D.V.M., M.P.H., Woodstock  
 Stuart Levin, M.D., Chicago  
 Daniel J. Pachman, M.D., Chicago  
 H. H. Rohrer, M.D., M.P.H., Peoria  
 Shelley S. Sansbury, Jr., Flora  
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 Laura Landrum, Chicago  
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 Lanson W. Russell, Peotone  
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 Suellen Johnson, Wheaton  
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 Arthur Rubenstein, M.D., Chicago  
 Sister Paulette O'Connell, Chicago  
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 Donna Stoner, Decatur  
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 Seymore H. Yale, D.D.S., Chicago

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 Yolanda Hall  
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 Virginia Hill  
 Marjorie Huffman  
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 Donald Sherline  
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Edward Lis, Springfield

Ivan Pavkovic, IDMHDD  
Robert Rechner, Springfield  
Jeri Rose, Chicago  
Nancy Russell, Springfield  
Rita Smith, Mt. Prospect  
Helen Whalen, Springfield  
Margaret Wingers, Brighton

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### **POISON CONTROL CENTERS IN ILLINOIS**

For information contact:  
Division of Emergency Medical Services & Highway Safety  
Illinois Department of Public Health  
525 W. Jefferson  
Springfield, 62761  
Phone: (217) 785-2080

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### **APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS**

Illinois Department of Public Health  
Division of Disease Control

For information contact:  
Mrs. Mary Mahoney—Coordinator, Direct Services Programs  
Illinois Department of Public Health  
Room 150, 535 West Jefferson Street, Springfield 62761  
Phone (217) 782-3303

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### **DEPARTMENT OF REGISTRATION AND EDUCATION**

320 W. Washington Street, Springfield 62786  
17 N. State Street, Chicago 60602

Gary L. Clayton, *Director*  
Glen D. Crick, *Deputy Director/Statewide Enforcement*  
John Dreiske, *Deputy Director/Licensing and Testing*  
Edward F. Bruno, *Assistant Deputy Director/Regulatory*  
Charles T. McHugh, M.D., *Medical Coordinator*  
Louis R. Vitullo, *Chief of Medical Investigations*

The department is primarily concerned with the registration, licensing and enforcement of 30 laws governing the different professions, trades and occupations, including the Medical Practice Act.

The Medical Examining Committee, appointed by the director of the Department, operates within the framework of

the act and is charged with the responsibility of supervising examinations for licensure and making recommendations to the Director to grant or refuse to grant licenses. The Medical Disciplinary Board, appointed by the Governor, reviews alleged violations of the Medical Practice Act, hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

#### **Medical Examining Committee**

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Sam Brinkley, D.C., Alton  
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Willard C. Scrivner, M.D., Belleville  
James B. Williams, M.D., Chicago

# MEDICAL PRACTICE ACT

*Sections from the Illinois Medical Practice which have been found to be of interest to the membership are reprinted below as provided by the Department of Registration & Education. This listing was current as of September 1, 1982. Persons seeking a copy of the Act in its entirety, or more current information, may contact the Department directly at their Springfield office. Copies of the attendant regulations governing physicians are also available.*

*Service on medical committees—Exemption from civil liability.* § 2b. While serving upon any Medical Utilization Committee, Medical Review Committee, Patient Care Audit Committee, Medical Care Evaluation Committee, Quality Review Committee, Credential Committee, Peer Review Committee or any other committee whose purpose, directly or indirectly, is internal quality control or medical study to reduce morbidity or mortality, or for improving patient care within a hospital duly licensed under the Hospital Licensing Act, or the improving or benefiting of patient care and treatment whether within a hospital or not, or for the purpose of professional discipline, any person serving on such committee, and any person providing service to such committees shall not be liable for civil damages as a result of his acts, omissions, decisions, or any other conduct in connection with his duties on such committees, except those involving willful or wanton misconduct. *Amended by P.A. 79-1434 § 7, eff. Sept. 19, 1976; P.A. 80-771, § 3, eff. Oct. 1, 1977.*

*Practice by person licensed in another state pending examination.* § 2c.

This act does not prohibit the practice of medicine by a person who is licensed to practice medicine in all of its branches in any other state of the United States or the District of Columbia who has applied in writing to the Department, in form and substance satisfactory to the Department, for a license to practice medicine in all of its branches and has complied with all of the provisions of Section 13, except the passing of an examination which may be given under Section 13, until:

- (a) the expiration of 6 months after the filing of such written application, or
- (b) the decision of the Department that the applicant has failed to pass an examination within 6 months or failed without an approved excuse to take an examination conducted within 6 months by the Department, or
- (c) the withdrawal of the application. *(Added by Act approved July 26, 1971)*

*Dispensing drugs or medicine—Label.* § 2d.

Any person licensed under this act who dispenses any drug or medicine shall dispense such drug or medicine in good faith and shall affix to the box, bottle, vessel or package containing the same a label indicating (a) the date on which such drug or medicine is dispensed; (b) the name of the patient; (c) the last name of the person dispensing such drug or medicine; (d) the directions for use thereof; and (e) the proprietary name or names or, if there is none, the established name or names of the drug or medicine, the dosage and quantity, except as otherwise authorized by regulation of the Department of Registration and Education. This Section shall not apply to drugs or medicines in a package which bears a label of the

manufacturer containing information describing its contents which is in compliance with requirements of the Federal Food, Drug and Cosmetic Act and the Illinois Food, Drug and Cosmetic Act and which is dispensed without consideration by a practitioner licensed under this Act. "Drug" and "medicine" have the meaning ascribed to them in the "Pharmacy Practice Act," approved July 11, 1955, as now or hereafter amended; "good faith" has the meaning ascribed to it in subsection (v) of Section 102 of the "Illinois Controlled Substances Act," approved August 16, 1971, as amended. *Formerly § 2c. Renumbered § 2d by P.A. 77-1849, § 3, eff. July 1, 1972. Amended by PA 82-162, eff. Jan. 1, 1982.*

§ 5. *Minimum standards of professional education.* Except as provided in Section 9a of this Act, the minimum standards of professional education to be enforced by the department in conducting examinations and issuing licenses shall be as follows:

1. *Practice of Medicine.* For the practice of medicine in all of its branches:

(a) For an applicant who is a graduate of a medical college before the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to graduation a 4 years' course of instruction of not less than 9 months each, in such medical college, or its equivalent, the time elapsing between the beginning of the first year and the ending of the fourth year having been not less than 40 months, and which was reputable and in good standing in the judgment of the department; and prior to taking such examination said applicant must present proof that he has completed a 4 years' course of instruction in a high school or its equivalent as determined by an examination conducted by the department.

(b) For an applicant who is a graduate of a medical college after the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to admission thereto 2 years' course of instruction in a college of liberal arts, or its equivalent, or in such medical college, and a course of instruction in a medical college in the treatment of human ailments, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, and in addition thereto, a course of clinical training of not less than 12 months in a hospital, such college of liberal arts, medical college and hospital having been reputable and in good standing in the judgment of the department. The time requirement of not less than 132 weeks within a period of 35 months, set forth above, may be reduced by the department upon recommendation of the Dean of the medical school in the case of programs involving students with advanced standing.

(c) For an applicant who is a graduate of a medical college or school in another country; that such applicant was a resident of this State for a period of five years prior to matriculating in such medical college or school; that such applicant completed a required course of instruction in the treatment of human ailments as offered by such college or school of medicine, which course shall have been not less than 132 weeks



in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of three years' course of instruction in an accredited college of liberal arts or its equivalent; that such applicant submit an application to an Illinois medical school and submit to such testing procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school, to determine equivalency of education compared to state norms, such testing could be utilized in placement of such applicant at a level appropriate to educational achievement; that such applicant may be placed by an Illinois medical school into the appropriate level of medical school, thru internship training, provided that applicant agrees to pay, either by a scholarship or some other personal means, such tuition and fees necessary to complete medical education, and provided that such applicant signs a statement in a form to be determined by the Department that upon successful completion of all licensure requirements applicant intends to practice medicine in this State. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicant shall be eligible for award of an M.D. degree and examination and licensing for the practice of medicine in all of its branches as provided in this act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

(d) Until September 1, 1988, for an applicant who has studied medicine at a medical college or school located outside the United States; that such applicant has completed all of the formal requirements of a foreign medical school except internship and/or social service, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of 3 years' course of instruction in an accredited college of liberal arts or its equivalent; that such an applicant has submitted an application to a medical school recognized by the Department and submitted to such evaluation procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school and that such applicant has satisfactorily completed one academic year of supervised clinical training under the direction of such medical school; and, after completion of said academic year of supervised clinical training, that such applicant has satisfactorily completed twelve months of post graduate training in an approved hospital having been reputable and in good standing in the judgment of the Department; and provided that such applicant sign a statement and a form, to be determined by the Department, that upon successful completion of all license requirements, applicant intends to practice medicine in this state. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicants shall be eligible for examination and licensing for the practice of medicine in all of its branches as provided in this Act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

Until September 1, 1988, satisfaction of the requirements of this sub-section shall be in lieu of the completion of any foreign internship and/or social service requirements, and no such requirements shall be a condition of licensure as a physician in this State.

Until September 1, 1988, satisfaction of the requirements of this sub-section shall be in lieu of certification by the Educational Council for Foreign Medical Graduates, and such certification shall not be a condition of licensure as a physician in this state for candidates who have completed the requirements of this sub-section.

Until September 1, 1988, no hospital licensed by the State, or operated by the State or political subdivision thereof, or

which receive State financial assistance, directly or indirectly, shall require an individual who at the time of his enrollment in a medical school outside the United States is a citizen of the United States, to satisfy any requirement other than those contained in this sub-section prior to commencing an internship or residency.

Until September 1, 1988, a document granted by a medical school located outside the United States which certifies completion of all of the formal training requirements of such foreign medical school except internship and/or social service; and satisfactory completion of the examination and academic year of supervised clinical training at a medical school recognized by the Department referred to in this sub-section shall be deemed the equivalent of the degree of Doctor of Medicine for purposes of licensure and practice as a physician in this State and shall possess all the rights and privileges thereof.

The Illinois Board of Higher Education may make grants to Illinois Medical Schools, public and private, for each applicant who commences his academic year of supervised clinical training under the direction of said medical school. Preference shall be given in the award of these grants to Illinois residents. The Illinois Board of Higher Education shall by regulation adopt reasonable guidelines for the distribution of funds authorized by this Act. (*Added by Act approved Sept. 7, 1974.*)

2. *Treating human ailments without drugs or medicines and without operative surgery.* For the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery:

(a) For an applicant who was a resident student and who is a graduate before July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments, which he specifically designated in his application as the one he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to graduation a 3 years' course of instruction of not less than 6 months each, the time elapsing between the beginning of the first year and the ending of the third year having been not less than 22 months, and which are reputable and in good standing in the judgment of the department and prior to taking the examination the applicant must present proof that he has completed a 4 years' course of instruction in high school, or its equivalent, as determined by an examination conducted by the department.

(b) For an applicant who was a resident student and who is a graduate after July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments which he specifically designated in his application as the one which he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to admission thereto a 4 years' course of instruction in a high school, and as a prerequisite to graduation therefrom a course of instruction in the treatment of human ailments, of not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months except that as to students matriculating or entering upon a course of study of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery during the years 1940, 1941, 1942, 1943, 1944, 1945, 1946 and 1947, the said elapsed time shall be not less than 32 months, such high school and such school, college, institution having been reputable and in good standing in the judgment of the department.

(c) For an applicant who is a matriculant in a chiropractic college after September 1, 1969, that such applicant shall be required as a prerequisite for admission to examine for licensure, to complete a 2 years' course of instruction in a



liberal arts college or its equivalent, and a course of instruction in a chiropractic college in the treatment of human ailments, such course as a prerequisite to graduation therefrom having been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, such college of liberal arts and chiropractic college having been reputable and in good standing in the judgment of the Department.

(d) For an applicant who is a graduate of a United States chiropractic college after the effective date of this amendatory Act of 1981, the college of the applicant must be fully accredited by the Commission on Accreditation of the Council on Chiropractic Education or its successor. Such graduates shall be considered to have met the minimum requirements which shall be in addition to those requirements set forth in the rules and regulations promulgated by the Department of Registration and Education.

(e) For an applicant who is a graduate of a chiropractic college in another country; that such chiropractic college be equivalent to the standards of education as set forth for U.S. chiropractic colleges.

3. *Midwifery.* For the practice of midwifery: That he be a graduate of a college of midwifery which requires as a prerequisite to admission thereto, a one year's course of instruction in a high school or its equivalent, and required as a prerequisite to graduation, a one year's course in such college of midwifery, the time actually spent under instruction in such college of midwifery to have been not less than 12 months; such high school or equivalent school, and such college of midwifery having been in good standing in the judgment of the department.

Without prejudice to licenses heretofore issued under this section, no further licenses shall be issued under this section after the effective date of this amendment.

(Amended by PA 80-368, eff. Oct. 1, 1977. Amended by PA 82-276, eff. Aug. 19, 1981.)

#### CONTINUING EDUCATION

Continuing education—Recommendations by Examining Committee

§ 5.1. The Department, based on the written recommendation of the Examining Committee, shall promulgate mandatory requirements of continuing education for persons licensed pursuant to this Act. In establishing such recommendations, the Committee shall:

- (1) Develop practical and meaningful criteria for defining and describing continuing education requirements which meet, but are not limited to, the following specifications:
  - (a) Readily available to all practicing physicians in Illinois without undue commitment of time away from practice and expense on the part of the practitioner.
  - (b) Compatible with existing requirements of licensing agencies in other states.
  - (c) Compatible with the requirements of medical specialty boards for recertification of specialty status.
  - (d) Compatible with the continuing education requirements developed by national medical specialty societies.
  - (e) Compatible with continuing education programs and requirements that are developed in federally mandated peer review programs and as a part of Professional Standards Review Organizations.
  - (f) Provides for differing requirements for licensees engaged in other than direct patient care (example: educators, researchers and those engaged in medical administration).

- (g) Provides for compatible requirements for licensees in the federal uniformed services, those engaged in formal residency and fellowship training programs, and licensees operating under hospital permit licensure.
- (2) Conceive, develop and evaluate procedures, materials and systems to carry out the administrative requirements of this legislation which include, but are not limited to, the following:
  - (a) Procedures for prompt and fair evaluation of reports of educational achievement submitted by licensees.
  - (b) Requirements and position descriptions for personnel engaged in reviewing and evaluating reports and continuing educational achievements submitted by licensees.
  - (c) A data recording system for gathering, analyzing, storing and retrieving information on individual licensee educational accomplishments.
  - (d) Provision for licensee to appeal adverse actions and temporary exemptions from requirements under unusual circumstances.
  - (e) Exemption from legal prosecution of all persons responsible for action taken under the program.
  - (f) Establishment of realistic budgeting and cost requirements for the personnel, and operational funds necessary to plan, develop and operate the program.
  - (g) Procedures for surveying and evaluating the effectiveness of the program.
  - (h) Orderly procedures for adequate notice to licensee of pending action that may result in non-renewal of license, including provisions for consultation and assistance in time for him to meet the requirements of this Act.
  - (i) Provision for an extension of license during any renewal period when a compliance audit of continuing education credits of any person licensed under this Act is undertaken. Such extension shall be for a period not to exceed 3 months within which such compliance audit shall be completed. Orderly procedures shall be developed by the Department for adequate notification and methods of determining compliance with any audit undertaken by the Department.
  - (j) Orderly procedures for establishing requirements for reinstatement of any license not renewed because the holder of such license has failed to demonstrate compliance with the continuing education requirements of the Rules and Regulations promulgated for the administration of this Section.

- (3) Develop adequate protection for information about licensee participation in continuing education as it pertains to all aspects of practice liability and the licensee's public image and his relationships with individual patients.
- (4) Develop an advisory panel for each category of licensee to advise and assist the department in developing and application of continuing education criteria, administrative procedures and policy.
- (5) Develop procedures for assuring that the educational opportunities available to licensees for fulfilling the requirements of this act are of appropriate scope, variety, depth and of high quality.

The Department shall enforce these requirements; however, the Department shall be empowered to waive enforcement of these requirements in localities where it is demonstrated that the absence of opportunities for such education would interfere with the adequacy of medical services in that locality. Amended by P.A. 80-1203, § 1, eff. June 30, 1978.

Section 14. (A) *Renewal.* The expiration date and renewal



period for each certificate of registration issued under this Act, shall be set by rule. The holder of a certificate of registration may renew such certificate during the month preceding the examination date thereof by paying the required fee. (*Amended by PA 82-149, eff. Jan. 1, 1982.*)

# REVOCATION OR SUSPENSION OF LICENSE, CERTIFICATE, OR PERMIT—PROBATION OR OTHER DISCIPLINARY ACTION

§ 16. The Department may revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act is this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or State hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon any of the following grounds:

1. Performance of an elective abortion in any place, locale, facility, or institution other than:

(a) a facility licensed pursuant to the "Ambulatory Surgical Treatment Center Act" as heretofore or hereafter amended;

(b) an institution licensed pursuant to "An Act relating to the inspection, supervision, licensing, and regulation of hospitals" approved July 1, 1953, as heretofore or hereafter amended; or

(c) an ambulatory surgical treatment center or hospitalization or care facility maintained by the State or any agency thereof, where such department or agency has authority under law to establish and enforce standards for the ambulatory surgical treatment centers, hospitalization, or care facilities under its management and control; or

(d) Ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government; or

(e) Ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation;

2. Performance of an abortion procedure in a wilful and wanton manner on a woman who was not pregnant at the time the abortion procedure was performed.

3. Conviction in this or another State of any crime which is a felony under the laws of this State or conviction of a felony in a federal court, unless such person demonstrates to the Department that he has been sufficiently rehabilitated to warrant the public trust;

4. Gross or repeated malpractice resulting in serious injury or death of a patient;

5. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;

6. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of a financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;

7. Habitual intemperance in the use of ardent spirits, narcotics or stimulants to such an extent as to incapacitate for performance of professional duties;

8. Holding one's self out to treat human ailments under

any name other than his own, or the personation of any other physician;

9. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery or in passing an examination therefor, or wilful and fraudulent violation of the rules and regulations of the department governing examinations;

10. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill, or of the efficacy or value of one's medicine, treatment or remedy therefor;

11. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;

12. Revocation or suspension of a medical license in a sister state;

13. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;

14. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act", as now or hereafter amended, or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, or from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection prohibits 2 or more corporations authorized by "The Medical Corporation Act", as now or hereafter amended, from forming a partnership or joint venture of such corporations, and providing medical, surgical and scientific research and knowledge by employees or these corporations if such employees are licensed under this Act, or from pooling, sharing, dividing, or apportioning the fees and monies received by the partnership or joint venture in accordance with the partnership or joint venture agreement. Nothing contained in this subsection shall abrogate the right of 2 or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divide a fee; provided, the patient has full knowledge of the division, and, provided, that the division is made in proportion to the services performed and responsibility assumed by each.

15. A finding by the Medical Disciplinary Board that the registrant after having his license placed on probationary status violated the terms of the probation.

16. Abandonment of a patient.

17. The use or prescription for use of narcotics or controlled substances (designated products) in any way other than for therapeutic purposes.

18. Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician.

19. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses

to divulge upon demand of the Department of Registration and Education.

20. Immoral conduct in practice as a physician, or repeated acts of gross misconduct.

21. Willfully making or filing false records or reports in his practice as a physician, including, but not limited to, false records to support claims against the medical assistance program of the Department of Public Aid under the Public Aid Code.

22. Willful omission to file or record, or willfully impeding the filing or recording or inducing another person to omit to file or record medical reports as required by law.

23. Solicitation of professional patronage by any corporation, agents or persons, or profiting from those representing themselves to be agents of the licensee.

24. Gross and willful and continued overcharging for professional services, including filing false statement for collection of fees for which services are not rendered, including, but not limited to, filing such false statements for collection of monies for services not rendered from the medical assistance program of the Department of Public Aid under the Public Aid Code.

25. Professional incompetence as manifested by poor standards of care or mental incompetency as declared by a court of competent jurisdiction.

26. Physical illness, including, but not limited to, deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill or safety.

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to a license or certificate on any of the foregoing grounds, except the ground numbered 9 (fraudulent grounds excepted) must be commenced within 3 years next after the conviction or commission of any of the acts described therein, except as otherwise provided by law; but the time during which the holder of the license or certificate was without the State of Illinois shall not be included within the 3 years.

The entry of any order or judgment by any circuit court establishing that any person holding a license or certificate under this Act is a person in need of mental treatment operates as a suspension of that license or certificate. That person may resume his practice only upon a finding by the Medical Disciplinary Board that he has been determined to be recovered from mental illness by the court and upon the Board's recommendation that he be permitted to resume his practice.

*Amended by P.A. 81-1136, § 1, eff. July 1, 1980; PA 82-185, eff. August 14, 1981; PA 82-263, eff. August 19, 1981.*

#### ADVERTISING

§ 16.01. Any person licensed under this Act may advertise the availability of professional services in the public media or on the premises where such professional services are rendered. Such advertising shall be limited to the following information:

(1) Publication of the person's name, title, office hours, address and telephone number;

(2) Information pertaining to his areas of specialization, including appropriate board certification or limitation of professional practice;

(3) Information on usual and customary fees for routine professional services offered which such information shall include notification that fees may be adjusted due to complications or unforeseen circumstances;

(4) Announcement of the opening of, change of, absence from, or return to business;

(5) Announcement of additions to or deletions from professional licensed staff;

(6) The issuance of business or appointment cards.

It is unlawful for any person licensed under this Act to use testimonials or claims of superior quality of care to entice the public. It shall be unlawful to advertise fee comparisons of available services with those of other persons licensed under this Act.

This Act does not authorize the advertising of professional services which the offeror of such services is not licensed to render. Nor shall the advertiser use statements which contain false, fraudulent, deceptive or misleading material or guarantees of success, statements which play upon the vanity or fears of the public, or statements which promote or produce unfair competition.

*Amended by P.A. 81-1136, § 1, eff. July 1, 1980.*

#### MEDICAL DISCIPLINARY BOARD

*Illinois State Medical Disciplinary Board. § 16.02.*

There is hereby created the Illinois State Medical Disciplinary Board, (hereinafter referred to as the "Board"). The Board shall consist of 7 members, appointed by the Governor by and with advice and consent of the Senate. All shall be residents of the State, not more than 4 of whom shall be members of the same political party. Five members shall be physicians licensed to practice medicine in all of its branches in Illinois. One member shall be an Illinois physician possessing the degree of doctor of osteopathy. One member shall be a person licensed in Illinois and possessing a chiropractor's degree.

a. Of the members of the Board first appointed, two shall be appointed for terms of 2 years, two shall be appointed for terms of 3 years, and three shall be appointed for terms of 4 years. Upon the expiration of the term of any member, his successor shall be appointed for a term of four years by the Governor by and with the advice and consent of the Senate. The Governor shall fill any vacancy for the remainder of the unexpired term by and with the advice and consent of the Senate. Upon recommendation of the Board, any member of the Board may be removed by the Governor for misfeasance, malfeasance, or willful neglect of duty after notice and a public hearing unless such notice and hearing shall be expressly waived in writing. Each member shall serve on the Board until his successor is appointed and qualified. No member of the Board shall serve more than two consecutive four year terms.

In making appointments the Governor shall attempt to insure that the various social and geographic regions of the State of Illinois are properly represented. In making the designation of persons to act for the several professions represented on the Board, the Governor shall give due consideration to recommendations by members of the respective professions and by organizations therein.

b. The Board shall annually elect one of its members as chairman, one as vice chairman and one as secretary. No officer shall be elected more than twice in succession to the same office. Each officer shall serve until his successor has been elected and qualified.

c. The secretary shall keep a record of the proceedings of the Board and shall be custodian of all books, documents and papers filed with the Board, including the minute book or journal of the Board. The secretary or other persons authorized by the Board may cause copies to be made of all minutes and other records and documents of the Board and may give certificates of the Board to the effect that such copies are true copies, and all persons dealing with the Board may rely upon such certificates.

d. Four members of the Board shall constitute a quorum. A vacancy in the membership of the Board shall not impair the right of a quorum to exercise all the rights and perform



all the duties of the Board. Any action taken by the Board under this Act may be authorized by resolution at any regular or special meeting and each such resolution shall take effect immediately. The Board shall meet at least quarterly. The Board is empowered to adopt all rules and regulations necessary and incident to the powers granted to it under this Act.

- e. Each member, and member-officer, of the Board shall receive a per-diem stipend as the Director of the Department of Registration and Education, hereinafter referred to as the Director, shall determine. Each member shall be paid his necessary expenses while engaged in the performance of his duties.
- f. The Director shall, in conformity with the "Personnel Code," as now or hereafter amended, select a medical coordinator, who shall not be a member of the Board. The medical coordinator shall be a physician licensed to practice medicine in all of its branches, and the Director shall set his rate of compensation. The medical coordinator shall be the chief enforcement officer of the Medical Practice Act and shall serve at the will of the Board. The Director shall employ, in conformity with the Personnel Code, not less than one (1) full time investigator for every 5000 physicians licensed to practice medicine in the State. Each investigator shall be a college graduate with at least two years' investigative experience or one year advanced medical education. Upon the written request of the Board, the Director shall employ, in conformity with the Personnel Code, such other professional, technical, investigative, and clerical help, either as a full or part-time basis as the Board deems necessary for the proper performance of its duties. All employees of the Board shall be directed by, and answerable to, the Board with respect to their duties and functions.
- g. Upon the specific request of the Board, signed by either the chairman, vice chairman, or medical coordinator of the Board, the Bureau of Drug Compliance, the Office of Professional Supervision of the Department of Registration and Education, the Illinois Law Enforcement Commission, the Illinois Bureau of Investigation, the Illinois Legislative Investigating Commission shall:
  - (1) Make available any and all information that they shall have in their possession regarding a particular case then under investigation by the Board.
- h. Members of the Board shall be immune from suit in any action based upon any disciplinary proceedings of other acts performed in good faith as members of the Board.

*Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.*

#### MEDICAL EXAMINING COMMITTEE

*Section 16.03.* There is hereby created a Medical Practice Examining Committee (hereinafter referred to as the "Committee"). The Committee shall be composed of 7 persons, 5 of whom shall be reputable physicians licensed to practice medicine and surgery in this State possessing the degree of doctor of medicine, one person shall be a reputable licensed physician possessing the degree of doctor of osteopathy, and one person shall be a reputable licensed physician possessing the degree of doctor of chiropractic. Of the 5 members holding the degree of doctor of medicine, one shall be a full-time teacher of professional rank in one of the clinical departments of the University of Illinois College of Medicine, or of the Southern Illinois University School of Medicine. For the purpose of preparing questions and rating papers on practice peculiar to any school, graduates of which may be candidates for registration or license, the Director may designate additional examiners whenever occasion may require.

The Committee shall receive the same compensation as

the members of the Illinois State Medical Disciplinary Board, which compensation shall be paid out of the Illinois State Medical Disciplinary Fund.

*(Added by PA 82-633, eff. Sept. 24, 1981.)*

*Suspension or revocation of license or certificate—Investigation—Notice—Hearing.*] § 17.01. Upon the motion of either the Department or the Board or upon the verified complaint in writing of any person setting forth facts which if proven would constitute grounds for suspension or revocation under Section 16 of this Act, the Board shall investigate the actions of any person, so accused who holds or represents that he holds a license or certificate. Such person is hereinafter called the accused.

The Department shall, before suspending, revoking, placing on probationary status, or taking any other disciplinary action as the Department may deem proper with regard to any license or certificate, at least 30 days prior to the date set for the hearing, notify the accused in writing of any charges made and the time and place for a hearing of the charges before the Board, direct him to file his written answer thereto to the Board under oath within 20 days after the service on him of such notice and inform him that if he fails to file such answer default will be taken against him and his license or certificate may be suspended, revoked, placed on probationary status, or have other disciplinary action, including limiting the scope, nature or extent of his practice, as the Department may deem proper taken with regard thereto.

Where a physician has been found, upon complaint and investigation of the Department, and after hearing, to have performed an abortion procedure in a wilful and wanton manner upon a woman who was not pregnant at the time such abortion procedure was performed, the Department shall automatically revoke the license of such physician to practice medicine in Illinois.

Such written notice and any notice in such proceedings thereafter may be served by delivery of the same personally to the accused person, or by mailing the same by registered or certified mail to the address last theretofore specified by the accused in his last notification to the Department.

*Amended by P.A. 81-302, § 1, eff. Jan. 1, 1980; PA 82-263, eff. August 19, 1981.*

*Hearings by board—Continuance—Failure to file answer—Disciplinary action—Temporary suspension of license without hearing.*] § 17.02. At the time and place fixed in the notice, the Board provided for in this Act shall proceed to hear the charges and both the accused person and the complainant shall be accorded ample opportunity to present in person, or by counsel, such statements, testimony, evidence and argument as may be pertinent to the charges or to any defense thereto. The Board may continue such hearing from time to time. If the Board is not sitting at the time and place fixed in the notice or at the time and place to which the hearing has been continued, the Department shall continue such hearing for a period not to exceed 30 days.

In case the accused person, after receiving notice, fails to file an answer, his license or certificate may in the discretion of the Director, having received first the recommendation of the Board, be suspended, revoked, placed on probationary status, or the Director may take whatever disciplinary action as he may deem proper, including limiting the scope, nature, or extent of said person's practice, without a hearing, if the act or acts charged constitute sufficient grounds for such action under this Act.

The Board has the authority to recommend to the Director that probation be granted or that other disciplinary action, including the limitation of the scope, nature or extent of a person's practice, be taken as it deems proper. If disciplinary



action other than suspension or revocation is taken, the Board may recommend that the Director impose reasonable limitations and requirements upon the accused registrant to insure compliance with terms of the probation or other disciplinary action including, but not limited to, regular reporting by the accused to the Department of his actions, placing himself under the care of a qualified physician for treatment, or limiting his practice in such manner as the Director may require.

The Director may temporarily suspend the license of a physician without a hearing, simultaneously with the institution of proceedings for a hearing provided under this Section if the Director finds that evidence in his possession indicates that a physician's continuation in practice would constitute an immediate danger to the public. In the event that the Director suspends, temporarily, the license of a physician without a hearing, a hearing by the Board must be held within 15 days after such suspension has occurred.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Subpoena of witnesses—Administration of oath.] § 17.03* The Board or Department has power to subpoena and bring before it any person in this State and to take testimony either orally or by deposition, or both, with the same fees and mileage and in the same manner as is prescribed by law for judicial procedure in civil cases.

The Director, Assistant Director, Superintendent of Registration and any member of the Board each have power to administer oaths at any hearing which the Board or Department is authorized by law to conduct.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Attendance of witnesses and production of books and papers.]*

*§ 17.04* Any circuit court upon the application of the accused person or complainant or of the Department or Board, may order the attendance of witnesses and the production of relevant books and papers before the Board in any hearing relative to the application for or refusal, recall, suspension or revocation of a license or certificate. The court may compel obedience to its order by proceedings for contempt.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Record of proceedings.] § 17.05* The Department, at its expense, shall provide a stenographer to take down the testimony and preserve a record of all proceedings at the hearing of any case wherein a license or certificate may be revoked, suspended, placed on probationary status, or other disciplinary action taken with regard thereto. The notice of hearing, complaint and all other documents in the nature of pleadings and written motions filed in the proceedings, the transcript of testimony, the report of the Committee and the orders of the Department constitute the record of such proceedings. The Department shall furnish a transcript of such record to any person interested in such hearing upon payment therefor of one dollar per page for each original transcript and 50¢ per page for each carbon copy thereof ordered with the original; except that the charge for any part of such transcript ordered and paid for previous to the writing of the original record thereof shall be 50¢ per page for each carbon copy.

*Amended by P.A. 77-2829, § 34, eff. Dec. 22, 1972; P.A. 78-255, § 61, eff. Oct. 1, 1973.*

*Report of findings and recommendations—Motion for Rehearing—Certificate of order of revocation, suspension, or other disciplinary action.] § 17.06.* The Board shall present to the Director a written report of its findings and recommendations. A copy of such report shall be served upon the accused person, either personally or by registered or certified mail. Within 20 days after such service, the accused person may present to the Department his motion in writing for a rehearing, which written motion shall specify the particular ground therefor.

If the accused person orders and pays for a transcript of the record as provided in Section 17.05, the time elapsing thereafter and before such transcript is ready for delivery to him shall not be counted as part of such 20 days.

At the expiration of the time allowed for filing a motion for rehearing the Director may take the action recommended by the Board. Upon the suspension, revocation, placement on probationary status, or the taking of any other disciplinary action, including the limiting of the scope, nature, or extent of one's practice, deemed proper by the department, with regard to the license, certificate or state hospital permit, the accused shall surrender his license or certificate to the Department, if ordered to do so by the Department, and upon his failure or refusal so to do, the Department may seize the same.

Each certificate or order of revocation, suspension, or other disciplinary action shall contain a brief, concise statement of the ground or grounds upon which the Department's action is based, as well as the specific terms and conditions of such action. This document shall be retained as a permanent record by the Board and the Director.

In those instances where an order or revocation, suspension, or other disciplinary action has been rendered by virtue of a physician's physical illness, including, but not limited to deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill, or safety, the Department shall only permit this document, the record of the hearing incident thereto, to be observed, inspected, viewed, or copied pursuant to court order.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Restoration of license or certificate.] § 17.07* At any time after the suspension, revocation, placing on probationary status, or taking disciplinary action with regard to any license or certificate, the Department may restore it to the accused person, or take any other action to reinstate the license to good standing, without examination, upon the written recommendation of the Board.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Review under Administrative Review Act—Venue.] § 17.08* All final administrative decisions of the Department are subject to judicial review pursuant to the provisions of the "Administrative Review Act", approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto. The term "administrative decision" is defined as in Section 1 of the "Administrative Review Act".

Such proceedings for judicial review shall be commenced in the Circuit Court of the County in which the party applying for review resides; but if such party is not a resident of this State, the venue shall be in Sangamon County.

The Department shall not be required to certify any record to the Court or file any answer in Court or otherwise appear in any Court in a Judicial review proceeding, unless there is filed in the Court with the complaint a receipt from the Department acknowledging payment of the costs of furnishing and certifying the record which costs shall be computed at the rate of 20 cents per page of such record. Exhibits shall be certified without cost. Failure on the part of the Plaintiff to file such receipt in Court shall be grounds for dismissal of the action. During the pendency and hearing of any and all Judicial proceedings incident to such disciplinary action the sanctions imposed upon the accused by the Department shall remain in full force and effect.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Order of revocation or suspension as prima facie evidence.] § 17.09* An order of revocation, suspension, placing the license on probationary status, or other formal disciplinary action as



the Department may deem proper, or a certified copy thereof, over the seal of the Department and purporting to be signed by the Director, is prima facie proof that:

1. Such signature is the genuine signature of the Director;
2. The Director is duly appointed and qualified; and
3. The Board and the members thereof are qualified.

Such proof may be rebutted.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Action and report of board—Reasons of disagreement by Director—Necessity for exercise of powers—Re-examination or re-hearing.] § 17.10*

None of the disciplinary functions, powers and duties enumerated in this Act shall be exercised by the Department except upon the action and report in writing of the Board.

In all instances, under this Act, in which the Board has rendered a recommendation to the Director with respect to a particular physician, the Director shall, in the event that he disagrees with or takes action contrary to the recommendation of the Board, file with the Board and the Secretary of State his specific written reasons of disagreement with the Board. Such reasons shall be filed within 30 days of the occurrence of the Director's contrary position having been taken.

The action and report in writing of a majority of the Board designated is sufficient authority upon which the Director may act.

Whenever the Director is satisfied that substantial justice has not been done either in an examination, or in a formal disciplinary action, or refusal to restore a license or certificate, he may order a re-examination or re-hearing by the same or other examiners.

*Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Confidentiality of information received at hearings.] § 17.11*

In all hearings conducted under this Act, information received, pursuant to law, relating to any information acquired by a physician in attending any patient in a professional character, necessary to enable him professionally to serve such patient, shall be deemed strictly confidential and shall only be made available either as part of the record of such hearing or otherwise; (1) when such record is required, in its entirety, for purposes of judicial review pursuant to this Act; or (2) upon the express, written consent of the patient, or in the case of his death or disability, of his personal representative.

*Added by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Liability for disciplinary action without reasonable basis in fact.] § 17.12* In the event that the Department's order of revocation, suspension, placing the licensee on probationary status, or other order of formal disciplinary action is without any reasonable basis in fact of any kind, then the State of Illinois shall be liable to the injured physician for those special damages he has suffered as a direct result of such order.

*Added by P.A. 79-1130, § 1, eff. Aug. 1, 1975.*

*Report of violations—Immunity from liability—Assistance in medical competency examinations—Hearing officers.] § 17.13*

Any physician licensed under this Act, the Illinois State Medical Society, the Illinois Osteopathic Association, the Chiropractic Association, or any component societies of any of these three groups, and any other person, may report to the Board any information such physician, association, society, or person may have which appears to show that a physician is or may be in violation of any of the provisions of Section 16 of the Medical Practice Act. Any such physician, association, society or person, participating in good faith in the making of a report, under this Act, shall have immunity from any liability, civil, criminal, or that otherwise might result by reason of such actions. For the purpose of any proceedings, civil or criminal, the good faith of any such physician, association, society or persons shall be presumed. The Board may request the Illinois State Medical Society, the Illinois Osteopathic Association, or the Illinois Chiropractic Association both to assist the Board in preparing for or conducting any medical competency examination as the Board may deem appropriate. The Board shall retain and use such hearing officers as it deems necessary.

*Amended by P.A. 80-965, § 1, eff. Sept. 22, 1977.*

*Punishment for doing certain acts without license.] § 24.* If any person holds himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings; or suggests, recommends or prescribes any form of treatment for the palliation, relief or cure of any physical or mental ailment of any person with the intention of receiving therefore, either directly or indirectly, any fee, gift, or compensation whatsoever; or diagnosticates or attempts to diagnosticate, operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment, of another; or maintains an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment; or attaches the title Doctor, Physician, Surgeon, M.D. or any other word or abbreviation to his name, indicating that he is engaged in the treatment of human ailments as a business; and does not possess a valid license issued by the authority of this State to practice the treatment of human ailments in any manner, he shall be sentenced as provided in Section 35.1.

*Amended by P.A. 77-2708, § 1, eff. Jan. 1, 1973.*

*§ 41. Releases from liability as condition of medical treatment is against public policy.* Any contract or agreement signed by any person prior to or as a condition of such person receiving medical treatment in any form, which releases from liability any physician, hospital or other health care provider for any malfeasance, misfeasance or nonfeasance in the course of administering any medical treatment or service is void and against the public policy of the State of Illinois.

*Added by P.A. 82-280, eff. July 1, 1982.*

## DEPARTMENT OF REHABILITATION SERVICES

623 East Admas Street  
Springfield, IL 62706  
Robert W. Granzeier, *Director*

The Department of Rehabilitation Services is a statutory agency which determines medical eligibility for applicants for cash benefits under Social Security Disability Insurance, Supplemental Security Income, provides rehabilitation services and operates residential/educational/rehabilitation facilities for disabled adults and children of or near public school age who cannot be appropriately served by community resources. Clients who have a vocational goal are provided appropriate

quality rehabilitation services including evaluation, education, training, guidance, counseling, job placement and other medical and support services. For eligible persons, the Department provides Home Services to severely disabled persons under the age of 60 who do not have a vocational goal but who are at risk of being institutionalized on a long-term basis. All services are provided directly or indirectly by the Department.

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# Doctor's News

**PHYSICIANS IN THE NEWS**—**J. L. Palumbo, M.D.**, Ashton, received an Abbott Golden Timepiece for 35 years of outstanding service and dedication to medicine upon his retirement this summer.

**Roy C. Watkins, M.D.**, director of emergency services for Bethany Hospital, has been named a fellow in the American College of Emergency Physicians (ACEP).

**Rosalind Catchatourian, M.D.**, Chicago, and **Kathleen Remlinger, M.D.**, Chicago, will administer Loyola University Medical Center's first ongoing Bone Marrow Transplant (BMT) program.

**Eugene J. Rogers, M.D.**, North Chicago, has been elected president of the Chicago Society of Physical Medicine and Rehabilitation and vice-president of the Illinois Society of Physical Medicine and Rehabilitation. Dr. Rogers is a member of the *IMJ* Editorial Board.

**Jerome Silver, M.D.**, Chicago, chairman of the Weiss Memorial Hospital department of surgery, was recently elected president of their board of governors.

**Subhash K. Shah, M.D.**, Chicago, has accepted the position of medical director of Mercy Health Care and Rehabilitation Center, Homewood. **Warren W. Furey, M.D.**, Hinsdale, received the Alumni Service Award from Northwestern University for his outstanding service.

**CMS EDUCATIONAL PROGRAMS**—The Chicago Medical Society Auxiliary will present "An Evaluation of Costs and Coverages," part two of a series on problems concerning the elderly, Wednesday, November 10 from 1:00 p.m.-3:00 p.m. at the CMS Building, 515 North Dearborn Street, Chicago.

CMS has also announced that the third and final session of their seminar for medical assistants will be held from 9:00 a.m.-4:30 p.m., October 27, at Papachinos Restaurant, 9401 S. Cicero Ave., Oak Lawn. The program is designed to help medical assistants sharpen their office skills and improve efficiency.

**CAUTION ON SOLICITATION**—Physicians who receive solicitation from Loretta J. McDevitt are urged to file a complaint with the postal authorities. Ms. McDevitt, widow of a chiropractor, is asking physicians for \$5.00 to \$10.00 to help start a home business. In return she will provide information on how to obtain a "miracle drug" Gervital G H-3. According to the *Los Angeles County Bulletin*, the FDA says that gerovital is merely a buffered and stabilized solution of procaine hydrochloride (novocaine) and is illegal in the United States. AMA sources indicate that there have been many complaints filed. Persons filing a complaint should submit a copy of the envelope in which the solicitation was received along with the original letter (retaining a copy).

**MEASLE ELIMINATION MONTH**—October 1982 has been slated the month to eliminate indigenous measles from the United States through a nationwide program. The Illinois Department of Public Health states that in Illinois the number of reported measles cases decreased from 1,636 in 1979 to 26 in 1981. Nationwide reported cases of measles dropped 99% in 1981 from the pre-vaccine era.

Support by Illinois physicians in immunizing preschool and school age children has had a significant impact on reducing the incidence of disease, reports the IDPH. Prompt reporting of suspect measles cases will speed epidemiological follow-ups and appropriate control measures. Rapid immunization of identified susceptibles, or exclusion of susceptibles from schools or day care centers will help ensure that spread cases do not occur or are greatly reduced.

Physicians may call the Illinois Department of Public Health Immunization Program Central Office, collect, Monday-Friday, 8:30 a.m.-5:00 p.m., at (217) 785-1455 to report a suspect measles case.



**MEDICAL ASSISTANTS WEEK**—The first National Medical Assistants Week will be held November 1-5 in conjunction with celebration of the founding of the American Association of Medical Assistants in 1956. The purpose of the week is to increase the awareness of professional medical assistants among members of other health professions and the general public. The 575 chapters of AAMA will sponsor local events to promote the week and increase the awareness and understanding of the medical assistants' duties and responsibilities.

**BLOOD SERVICES REPORT**—The American Blood Commission has announced the availability of a new publication, "State Legislative Initiatives in Blood Services: A Status Report." The publication contains complete information on bills affecting the providers and users of blood resources and services. The report is available from the American Blood Commission for \$5.00 plus postage and handling. To order contact: Communications, American Blood Commission, 1901 N. Ft. Myer Drive, Suite 300 Arlington, VA. 22209.

**A CARIBBEAN AIR/SEA CRUISE**, departing Chicago & St. Louis on March 16, returning March 26, 1983, has been planned with INTRAV. This eleven-day cruise aboard Sitmar's TSS FAIRWIND, will visit St. Thomas, Antigua, Barbados, Martinique and St. John. For more information, please contact the Travel Department of ISMS Headquarters.

**MEDICAL-LEGAL CONFERENCE**—"Legal Issues in Clinical Practice," a two day conference, will be held at the Ambassador West Hotel, Chicago November 11-12. Physicians, nurses, hospital administrators, legal representatives for hospitals and other interested medical and/or legal professionals can participate in workshops and attend sessions on such topics as malpractice and hospital liability, impaired health professionals, patients' rights, and allocating health resources.

Co-sponsors for the event are the American Society of Law and Medicine, ISMS and the Medico-Legal Relations Committee of the Chicago Bar Association. Registration fee is: \$175 for members of the cooperating sponsors; \$195 for non-members; and \$150 each for two or more members from the same organization.

For more information contact the American Society of Law and Medicine, 765 Commonwealth Ave., 16th floor, Boston, Massachusetts 02215 or call (617) 262-4990.

**PHYSICIAN PLACEMENT SERVICE**—The Veterans Administration has established a Physician Placement Service that enables VA Medical Centers throughout the United States to identify physicians who meet the specialty needs of the centers. Interested physicians can apply for any opening by submitting a single application to the Physician Placement Service. The computerized service matches qualifications and practice preferences with VA Center requirements. For more information contact, VA Physician Service, P.O. Box 791, Randolph, MA 02368 or call 1-800-343-8831 (outside of Massachusetts) or 1-617-963-8282 collect (Massachusetts residents).

**EPILEPSY FORUM**—The Epilepsy Services of Chicago will hold the annual Forum on Epilepsy on Thursday November 4 from 6:00 p.m.-9:00 p.m. at Chicago's First National Plaza Auditorium (Dearborn and Madison Streets). Various booths will represent different aspects of epilepsy and services available to persons with epilepsy. At 8:00 p.m. four expert neurologists will have a panel discussion and answer questions from the audience. Admission is free. For more information call Epilepsy Services of Chicago at (312) 332-4107.

**QUALITY ASSURANCE SEMINAR**—Physicians, coordinators and other health related personnel can attend an educational seminar, "The Alternative Programs in Peer Review and Quality Assurance 1981-84," at the Chicago Marriott October 23-24, 1982. Seminar topics include utilization review, quality assurance, risk management and cost containment. The two-day seminar is sponsored by the American College of Utilization Review Physicians.

# Convention Handbook



## INTERIM MEETING '82

November 13-14

**Sheraton-St. Louis Hotel  
910 North Seventh Street  
St. Louis, Missouri**

Members of the House of Delegates  
Delegates and Alternate Delegates to the Illinois State  
Medical Society  
Officers of County Medical Societies  
ISMS Delegation to the American Medical Association  
Committees of the House of Delegates  
Resolutions

### **CALLS WILL REACH YOU EASILY AT THE 1982 INTERIM SESSION**

Doctor, please inform your staff that while you are attending the ISMS interim meeting, you may be reached through the ISMS Physician's Message Center from 9 a.m. to 4 p.m. Saturday and 9 a.m. to 11:30 a.m. Sunday at this number:

**314-231-5100**



# Members of the 1982 Interim Meeting House of Delegates

## OFFICERS

President .....	Cyril C. Wiggishoff
President-Elect .....	Robert P. Johnson
1st Vice President .....	Maynard I. Shapiro
2nd Vice President .....	Eugene P. Johnson
Secretary-Treasurer .....	Jere E. Freidheim
Speaker of the House .....	Clifton Reeder
Vice Speaker .....	Julian Buser

## TRUSTEES

First District .....	John J. Ring	1984	Fourth District .....	George Burke	1985
Second District .....	Allan L. Goslin	1983	Fifth District .....	Robert Prentice	1985
Third District .....	Richard Blankshain	1985	Sixth District .....	Robert R. Hartman	1984
	Alfred Clementi	1985	Seventh District .....	Alfred J. Kiessel	1985
	Audley F. Connor, Jr.	1983	Eighth District .....	Arthur R. Traugott	1985
	Morris T. Friedell	1984	Ninth District .....	Warren D. Tuttle	1984
	Robert C. Hamilton	1983	Tenth District .....	Thomas P. Meirink	1984
	Henrietta Herbolzheimer	1984	Eleventh District .....	Kenneth A. Hurst	1983
	Lawrence L. Hirsch	1984	Twelfth District .....	Joseph Perez	1983
	Harold J. Lasky	1983	Trustee-at-Large .....	Fred Z. White	
	Richard N. Rovner	1983	Chairman of the Board .....	Warren D. Tuttle	
	Joseph Sherrick	1983			

*Members of the House who have the privilege of the floor without the right to vote in this capacity*

## Past Presidents

J. Ernest Breed*	1971	Fredric D. Lake*	1975
Herschel Browns*	1981	Burtis E. Montgomery*	1966
Edward W. Cannady*	1970	Caesar Portes*	1967
Newton DuPuy*	1968	Jacob E. Reisch, Honorary*	1979
Harlan English*	1964	Willard C. Scrivner*	1974
David S. Fox*	1979	P. John Seward*	1980
H. Close Hesseltine*	1961	Joseph H. Skom*	1977
J. M. Ingalls	1976	Leo P. A. Sweeney*	1953
C. J. Jannings, III	1972	Philip G. Thomsen*	1969
Frank J. Jirka, Jr*	1973	Fred Z. White*	1982
		George T. Wilkins	1978

*\*Also a past trustee or councilor*

## Delegates to AMA

Herschel Browns	Henrietta Herbolzheimer	P. John Seward
Howard C. Burkhead	Lawrence L. Hirsch	Maynard I. Shapiro
David S. Fox	Morgan M. Meyer	Joseph H. Skom
Morris T. Friedell	Joseph R. O'Donnell	Cyril C. Wiggishoff
Jack L. Gibbs	John J. Ring	George T. Wilkins
Theodore Grevas		

## Past Trustees or Councilors

Walter C. Bornemeier	Third District	Paul F. Mahon	Fifth District
Julian Buser	Tenth District	Joseph R. O'Donnell	Eleventh District
Raymond DesRosiers	Third District	Mather Pfeifferberger	Sixth District
Herbert Dexheimer	Tenth District	Ralph N. Redmond	Second District
Alfred Faber	Third District	George Shropshire	Third District
Robert T. Fox	Third District	Darrell H. Trumpe	Fifth District
Lee N. Hamm	Fifth District	Frederick E. Weiss	Third District
Eugene Hoban	Third District	Charles K. Wells	Ninth District
Ross Hutchison	Eleventh District	Cyril C. Wiggishoff	Third District
Eugene P. Johnson	Eighth District	Herman Wing	Third District
James Laidlaw	Eighth District	Warren Young	Third District
Ted LeBoy	Third District	Paul P. Youngberg	Fourth District
A. Edward Livingston	Fifth District		

# Delegates and Alternate Delegates to the Illinois State Medical Society

## DOWNSTATE DELEGATES

<i>County</i>	<i>Delegates</i>	<i>Alternate Delegates</i>
<b>District #1</b>		
KANE (4)	A. Beaumont Johnson Wayne Leimbach Francis Oslay George Shimkus	Kenneth Albrecht Robert Flanigan James C. Pritchard William Sheehy
LAKE (6)	Hugh Falls David Littman Eugene Pitts David Shapiro P. L. Vinciguerra	Albino Bismonte Homer Goldstein Richard K. Hawkins David S. Helberg Burton Miller
McHENRY	Arthur A. Woloshin August M. Rossetti	Robert Munson William Larsen
<b>District #2</b>		
BUREAU LASALLE LIVINGSTON MARSHALL-PUTNAM WOODFORD	Kent McQueen E. J. Fesco Dalisay Bello E. R. Resurreccion, Jr. Ronald Meyer	Louis Lukancic Richard Schmidt Gregorio Manabat Joe Cannon Hans Riggert
<b>District #4</b>		
FULTON HANCOCK HENDERSON HENRY-STARK KNOX McDONOUGH MERCER PEORIA (6)	Jack Gibbs C. F. Eddingfield Silvino C. Lindo Reinert Svendsen, Jr. Jerry Ramunis Richard Iverson Monty P. McClellan Ernest F. Adams Dean R. Bordeaux Lorris Bowers James DeBord Richard H. Lee Paul Norris	Rod Maguire James Coeur  James Parsons Irene Caruso Lawrence Kerr Mohamed Rajput Joseph Dean James E. Maher Tim C. Miller J. Kevin Paulsen John J. Taraska David E. Trachtenbarg Charles Dyke Robert Lelonek Charles Pogue Henry C. Zingher Robert L. Tucker V. Arora
ROCK ISLAND (3)	James F. Duesman Manuel O. Guerrero Richard Snodgrass Robert E. Cox Robert M. Wright K. E. Ambrose	
SCHUYLER TAZEWELL WARREN		
<b>District #5</b>		
DEWITT LOGAN	S. Kolandaivelu Edward Ulrich	Robert E. Myers James Borgerson



<i>County</i>	<i>Delegates</i>	<i>Alternate Delegates</i>
McLEAN (2)	Loren Boon Robert Reardon Jack Means	Robert E. Knight Wil Thielemann John W. McHarry, Jr.
MASON		
MENARD		
MONTGOMERY	Roger Wujek	Herbert Swarsen
SANGAMON (5)	Towfig M. Arjmand Edward G. Ference John Holland Michael Snyder Elvin Zook	John Dietrich Robert B. Dodd Stefan Kozak Marion Panepinto Ronald Staubly

## District #6

ADAMS	Marvin Grote	Walter Stevenson, III
GREENE	Jose P. Parcon	Ludwig Dech
JERSEY-CALHOUN	Neal Gipson	Herman Wuestenfeld
MACOUPIN	Robert G. England	Anand Talcherkar
MADISON (3)	E. K. DuVivier	Robert F. Hamilton
	Melvin Freedman	Rosalyn Lepley
	George T. Wilkins	Edward Ragsdale
MORGAN-SCOTT	Frank Norbury	Joseph Winterhalter
PIKE	Carlos B. Lara	Ronald L. Johnson

## District #7

BOND	Boyd McCracken, Sr.	M. K. Kaufmann
CHRISTIAN	Edward D. Slifer	
CLAY		
CLINTON	Wilson L. DuComb	Francis H. Ketterer
EFFINGHAM		
FAYETTE	Joshua Weiner	Hans Rollinger
MACON (2)	Randolph G. Emerson	S. Chadwick
	Delbert H. Hahn, Jr.	S. Goetter
MARION	Richard Rudman	E. F. Stephens, III
MOULTRIE	Eugene J. Boros	Phillip Best
PIATT	George G. Green	William E. Mundt
SHELBY	Edwin J. Siroy	Urbano Daut

## District #8

CHAMPAIGN (3)	Harlan Failor	Victor Feldman
	Lewis Trupin	Harold Kolb
	Robert Welke	
CLARK	Steven Macke	George Mitchell
COLES-CUMBERLAND	Mack W. Hollowell	Joseph Mallory
CRAWFORD	Charles Salesman	Dean J. Pelley
DOUGLAS	Humberto Mondul	Robert N. Arrol
EDGAR	J. M. Ingalls	Duane Haskell
JASPER		
LAWRENCE	Gary D. Carr	Larry Herron
RICHLAND	Charles A. DeKovessey	Enrique Bouffard, III
VERMILION	Raja Sadiq	W. F. Hensold

## District #9

ALEXANDER	Gemo Y. Wong	Charles L. Yarbrough
EDWARDS		
FRANKLIN	James Durham	
GALLATIN	John E. Doyle	
JACKSON	Paul P. Lorenz	Eli L. Borkon
JEFFERSON-HAMILTON	Charles K. Wells	H. Goff Thompson
JOHNSON		

<i>County</i>	<i>Delegates</i>	<i>Alternate Delegates</i>
MASSAC	Enrique Y. Yap	Benito Bajuyo
PULASKI	A. L. Robinson	
SALINE-POPE-HARDIN	A. Z. Goldstein	Larry Jones
UNION	Thomas Davis	William Whiting
WABASH	E. Lowenstein	Roger Fuller
WAYNE	E. B. Loftin	
WHITE	Phillip Boren	
WILLIAMSON	Herbert V. Fine	Robert Kane

## District #10

MONROE	E. F. Maglasang	Russell W. Jost
PERRY	C. E. Cawvey	B. A. Kinsman
RANDOLPH	O. W. Pflasterer	Allan Liefer
ST. CLAIR (4)	Wallace Berkowitz	Charles Frazer, Jr.
	Lloyd Thompson	Donald I. Serot
	Robert Wanless	
	Ronald Welch	
WASHINGTON	Gary A. Goforth	

## District #11

DUPAGE (10)	Peter Brusca	Anita Balodis
	James P. Campbell	Raymond A. Dieter, Jr.
	William B. Frymark	Robert D. Dooley
	Joseph P. McKay	Willard Elyea
	Morgan M. Meyer	Robert Fitzgerald
	Joseph R. O'Donnell	William P. Gibbons
	William C. Perkins	Sharon Pelton
	Garth Smith	Erlo Roth
	Thomas W. Stach	Ronald M. Severino
	Harold Walgren	
FORD	Ross Hutchison	Somchai Supawanich
IROQUOIS	R. K. Swedlund	J. E. Dailey
KANKAKEE	Donald Parkhurst	H. P. Swartz
KENDALL	Walter H. Brill	Michael R. Saxon
WILL-GRUNDY (4)	Robert J. Becker	Van L. Hicks
	Albert W. Ray, Jr.	Kenneth P. Jesunas
	Stanley Rousonelos	Theodore Kanellakes
	Kenneth M. Uznanski	John D. Walter

## District #12

BOONE	Earl Davis	Kent Hess
CARROLL	Benjamin Sy	C. G. Piper
DEKALB	John W. Ovitz, Jr.	Dean Miller
JO DAVIESS	Francis Waites	Delbert Williams
LEE	Donald Edwards	Kyu Jin Cho
OGLE	Don E. Hinderliter	Vincenzo Traina
STEPHENSON	William H. Isham	F. H. DesCourouez
WHITESIDE	John Hubbard	Girish R. Bhatt
WINNEBAGO (5)	Robert Behmer	Robert Bertrand
	Raymond Hoffmann	Gareth Eberle
	William Kobler	John Leonard
	F. H. Riordan, III	Warren Lowry
	Jerome Weiskopfe	Daniel Swift

## Medical Student Section Resident Physicians Section

Malcolm Major	Patrick Merrill
David Whitney	Michael Nieder



## COOK COUNTY DELEGATES

### *Delegates*

Aaronson, Donald  
 Andelman, Samuel L.  
 Andersen, James H.  
 Armstrong, Claesa  
 Bartolome, Juanito  
 Berg, Max

Bogen, Gilbert  
 Bragman, Robert  
 Branovacki, Eugene  
 Brislen, Andrew J.  
 Budrys, Stanley  
 Burkhead, Howard C.

Ciskoski, Ronald J.  
 Coleman, John M.  
 Costanzo, Vincent A.  
 Cross, Roland R.  
 Czeisler, Tibor  
 Danckers, Ulrich F.

DeJong, George A.  
 Diaz, Alfonso  
 Diffenbaugh, W. G.  
 Driscoll, John E.  
 Elward, Kurtis  
 Fagan, Peter T.

Falloon, Edwin L.  
 Farah, George S.  
 Fischer, Arthur  
 Fish, William  
 FitzGibbons, James P.  
 Flaherty, B. P.

Flanagan, C. Larkin  
 Frankel, Jerome J.  
 Gertz, George  
 Gonzales, Martin  
 Green, Martin W.  
 Guerrero, Severo K., Jr.

Harrod, John  
 Harwood, Thomas P.  
 Hinkamp, Joseph F.  
 Hoban, Eugene  
 Hoeltgen, Maurice  
 Horton, Loren B.

Hrejsa, Allen J.  
 Hughes, Joseph  
 Hutchinson, William A.  
 Hyde, John S.  
 Jensen, Harold  
 John, Thomas

Joslyn, A. Everett, Jr.  
 Kahn, Sidney C.  
 Kalsch, Harry E.  
 Kaz, Alex H.  
 Kirschenbaum, M. Barry  
 Kobak, Mathew

Kwinn, Frank C.  
 Lagorio, George L.  
 Libman, Robert H.  
 Lobraico, Rocco V., Jr.  
 Lukaszewski, Edwin J.

### *Alternate Delegates*

Ahstrom, James, Jr.  
 Banuchi, Fedor F.  
 Beck, Charles A.  
 Becker, Frank O.  
 Bellows, Randall  
 Bihl, John

Borelli, Nelson  
 Brown, Finley, Jr.  
 Brown, Murray C.  
 Budrys, Milda  
 Burdick, Allison L., Jr.  
 Burdick, Allison L., Sr.

Burke, Edward A.  
 Carroll, Catherine G.  
 Chaljub, Najib  
 Christensen, Eldis M.  
 Christou, Anastase A.  
 Cucco, Ullisse P.

DeTrana, Frank E.  
 DiMarco, Eugene R.  
 Doyharzabal, Roger  
 Elegant, Lawrence D.  
 Fabian, Sydney  
 Feldman, Sydney

Filipowicz, Roman I.  
 Forgione, Hebe M.  
 Friedell, Peter E.  
 Gianasi, Charles  
 Gnade, Gerard R.  
 Goodman, Harold

Gorday, Rose L.  
 Gorny, Edward J.  
 Goyal, Arvind K.  
 Graham, James  
 Graudins, Gunars  
 Gueyikian, Berj

Gutierrez, Antonio  
 Handler, Jerome L.  
 Johnson, M. Anita  
 Jones, Richard  
 Keer, Larry M.  
 Keifer, John W.

Knudson, John A.  
 Konecny, Philip  
 Landau, Richard L.  
 Lipsich, Michael  
 Lucina, Pedro A.  
 Mason, John W.

McCabe, Mary Joan  
 Meccia, Donald  
 Meyenberg, John  
 Mikhail, Kamel A.  
 Modi, C.M.  
 Mostowfi, Kiumars

Munoz, Maria  
 Muriel, Hugo H.  
 Mustell, Robert R.  
 Neumann, Helen A.  
 Nicholas, Everett E.

### *Delegates*

MacNerland, Robert H.  
 Marshall, William  
 Miller, Russell  
 Murray, Meredith B.  
 Nemecek, Raymond W.  
 Neskodny, J. F.

Odiaga-Garcia, Ignacio  
 O'Sullivan, Donal D.  
 Okner, Henry B.  
 Ostrowski, Fabian  
 Pamintuan, Rodolfo L.  
 Panayotou, Irene

Perritt, Richard  
 Peterson, Arthur R.  
 Petty, David T.  
 Quinlan, Donald  
 Razim, Edward A.  
 Rice, C. Malcolm, Jr.

Romanus, Raymond J.  
 Rothstein, David A.  
 Ruzich, Stanley  
 Santos, Antonio  
 Saulys, Augusta Z.  
 Schifano, Joseph

Schimmel, Samuel J.  
 Sedlak, Frank  
 Seed, Randolph  
 Simon, Arnold  
 Sinaiko, Edwin S.  
 Smith, C. Otis

Soboroff, Burton J.  
 Solon, Earl N.  
 Springer, Harry  
 Staley, Warren H.  
 Stephens, Natalie  
 Suckow, Earl E.

Sugar, Sam J.  
 Swartz, Robert M.  
 Tansey, William J.  
 Tekdogan, Mehmet M.  
 Thompson, J. Robert  
 Tovar, Jorge

Triester, Michael R.  
 Ungar, Jacob  
 Vega, Jesus  
 Walkowiak, Lydia  
 Wehrmacher, Wm. H.  
 Williams, Jack  
 Zurita, Victor

### *Alternate Delegates*

Nikurs, Lydia  
 Nosal, Roger  
 Nourbakhsh, M.  
 Olen, Richard N.  
 Olivar, Adriano  
 Palmer, Arthur

Panton, John H.  
 Pantone, Anton M.  
 Pill, Michael P.  
 Podzamsky, George  
 Poma, Pedro A.  
 Proffer, Dirk

Pruc, Jeremias N.  
 Renga, Dominick  
 Rezvan, A.  
 Richardson, James M.  
 Rodriguez, Alberto E.  
 Rodriguez, Ignacio

Saltiel, Isaac  
 Saulys, Vacys  
 Schall, Samuel M.  
 Schuetz, John N.  
 Schwartz, Malcolm  
 Schwartz, Sheldon D.

Seglin, Melvin N.  
 Senno, Aref  
 Short, Marshall  
 Siedentop, Karl H.  
 Smith, William S.  
 Sprang, Milton L.

Stevenson, George  
 Stockhammer, Dan  
 Strohl, Lee H.  
 Study, Robert S.  
 Sultan, Thomas R.  
 Sutoris, Edward D.

Talso, Peter J.  
 Thampy, Kishore J.  
 Thomas, Andrew R.  
 Tobin, John T.  
 Zitek, Russell W.

# Officers of County Medical Societies 1982

COUNTY	PRESIDENT	SECRETARY
ADAMS Members: 105-Dist. 6 Maxine Boyer, Ex. Sec. 1118 Broadway Quincy 62301	Randall McClelland 1888 Main, Quincy 62301	Richard L. Newman 1124 Broadway, Quincy 62301
ALEXANDER Members: 10-Dist. 9	Gemo Wong 529 Cross, Cairo 62914	Charles L. Yarbrough 800 Commercial, Cairo 62914
BOND Members: 9-Dist. 7	Thomas D. Dawdy 100 N. Locust, Greenville 62246	Boyd A. McCracken 100 N. Locust, Greenville 62246
BOONE Members: 22-Dist. 12	Kent Hess 2170 Pearl St., Belvidere 61008	John Steinkamp 824 S. Van Buren, Belvidere 61008
BUREAU Members: 40-Dist. 2	Merle Piacenti 600 E. 1st St., Spring Valley 61362	Swasdi Pothikamjorn 4040 Progress Blvd., Peru 61354
CARROLL Members: 8-Dist. 12	Lemuel B. Hussey P.O. Box 99, Savanna 61074	Cecil G. Piper 203 W. Market St., Mt. Carroll 61053
CASS-BROWN Members: 1-Dist. 6		
CHAMPAIGN Members: 230-Dist. 8 Larry Booth, Ex. Sec. 1408 W. University Urbana 61801	Bruce W. Miller 104 W. Clark, Champaign,	Paul W. Yardy 602 W. University, Urbana 61801
CHRISTIAN Members: 26-Dist. 7	Deogracias F. Quizon 217 S. Locust, Pana 62557	I. Del Valle 311 S. Main, Taylorville 62568
CLARK Members: 6-Dist. 8	George T. Mitchell Cork Medical Center, Marshall 62441	Eugene P. Johnson P. O. Box 68, Casey 62420
CLAY Members: 7-Dist. 7	Donald L. Bunnell Flora Clinic, Flora 62839	Eugene Foss P.O. Box 250, Flora 62839
CLINTON Members: 12-Dist. 7	Michael A. Bateman 541 Ninth St., Carlyle 62231	James A. Kirby 401 N. Main, Breese 62230
COLES-CUMBERLAND Members: 55-Dist. 8	Asit Basu 921 Eighteenth St., Charleston 61920	Joseph B. Mallory Sarah Bush Lincoln Health Center, Mattoon 61938
COOK Members: 8498-Dist. 3 Fred Schwartz, Exec. Dir. 515 N. Dearborn St. Chicago, IL 60610	Alfred J. Clementi 675 W. Central Road Arlington Hts., 60005	Richard H. Blankshain 715 Lake St., Oak Park 60301
CRAWFORD Members: 11-Dist. 8	Frank Gross 1002 Allen, Robinson 62454	W. B. Schmidt Schmidt Clinic, Robinson 62454
DEKALB Members: 63-Dist. 12	Thomas Kirts 232 S. Second St., DeKalb 60115	William F. Stach 407 W. State St., Sycamore 60178



COUNTY	PRESIDENT	SECRETARY
DEWITT Members: 10-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
DOUGLAS Members: 7-Dist. 8	Robert N. Arrol 126 S. Locust, Arcola 61910	Grant A. Jones 318 S. Ash, Arthur 61911
DUPAGE Members: 707-Dist. 11 Lillian Widmer, Ex. Sec. 800 Roosevelt Road Building B-Suite 300 Glen Ellyn 60137	Peter A. Brusca 503 Thornhill Dr., Carol Stream 60187	James P. Campbell 322 N. Blanchard St., Wheaton 60187
EDGAR Members: 15-Dist. 8	Duane Haskell 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
EFFINGHAM Members: 16-Dist. 7	P. D. L. Nayak 401 N. Mulberry St. Effingham 62401	P. D. L. Nayak 401 N. Mulberry St. Effingham 62401
FAYETTE Members: 7-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Vasudev Kachgal 802 N. Eighth St., Vandalia 62471
FORD Members: 11-Dist. 11	George Elfers Bellflower 61724	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
FRANKLIN Members: 30-Dist. 9	Yihnan Chiou 502 W. St. Louis St., Frankfort 62896	R. G. Thompson 309 W. St. Louis St., W. Frankfort 62896
FULTON Members: 40-Dist. 4	Jessie M. Reyes 210 W. Walnut, Canton 61520	Thomas C. Schrepfer 511 Promenade, Havana 62644
GALLATIN Members: 2-Dist. 9		John E. Doyle Ridgway 62979
GREENE Members: 6-Dist. 6	Jude A. Caselton 727 South 9th, Carrollton 62016	James C. Reid 712 S. College, Greenfield 62044
HANCOCK Members: 12-Dist. 4	Vasant Pawar Memorial Hospital, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
HENDERSON Members: 2-Dist. 4	Silvino Lindo, Jr. Biggsville 61418	Silvino Lindo, Jr. Biggsville 61418
HENRY-STARK Members: 36-Dist. 4	Randall L. Mullin 648 North Chicago, Geneseo 61254	Hipolito C. Lopez, Jr. 716 Elliott, Kewanee 61443
IROQUOIS Members: 20-Dist. 11	Jeffrey Swider 106 Prof. Arts Bldg., Rts 1 & 24E Watseka 60970	Philip Zumwalt 160 E. Grove, Sheldon 60966
JACKSON Members: 113-Dist. 9	Adiraju Palagiri Carbondale Clinic, Carbondale 62901	Adiraju Palagiri Carbondale Clinic, Carbondale 62901
JASPER Members: 2-Dist. 8	Monico Low 609 S. Van Buren, Newton 62448	Juan J. Serra 507 W. Washington, Newton 62448
JEFFERSON-HAMILTON Members: 37-Dist. 9	Charles Longwell, Jr. #1 Doctors Park, Mt. Vernon 62864	Kenneth Peart #1 Doctors Park, Mt. Vernon 62864
JERSEY-CALHOUN Members: 10-Dist. 6	Abbas Assar 122 E. Bridgeport, Whitehall 62092	Bernard Baalman Medical Center, Hardin 62047
JO DAVIESS Members: 9-Dist. 12	David Hockman 219 Summit St., Galena 61036	Wilbur Johnson 219 Summit St., Galena 61036

COUNTY	PRESIDENT	SECRETARY
KANE Members: 320-Dist. 1 H. Michael Wild, Ex. Dir. 355 First St. Batavia 60510	John A. O'Dwyer 34 N. Water, Batavia 60510	Nasir Jamal Ahmad 296 W. Spring St., So. Elgin 60177
KANKAKEE Members: 111-Dist. 11	Ray R. Schale 475 W. Merchant St., Kankakee 60901	Charles F. Lind 500 W. Court St., Kankakee 60901
KENDALL Members: 8-Dist. 11	Walter Brill Main St., Oswego 60543	John P. Cullinan Oswego 60543
KNOX Members: 82-Dist. 4 Mrs. Jane Gau, Exec. Sec. Galesburg Cottage Hospital 695 N. Kellogg Galesburg 61401	Homer L. Fleisher, Jr. 904 East Main, Knoxville 61448	Martin D. McDermott 555 N. Kellogg, Galesburg 61401
LAKE Members: 415-Dist. 1 Julia Schultz, Ex. Sec. P.O. Box 148 Gurnee 60031	Edward Leslie 935 Glen Flora, Waukegan 60085	David Shapiro 704 Paddock La., Libertyville 60048
LASALLE Members: 102-Dist. 2	James B. Aplington 206 Marquette St., LaSalle 61301	Allan L. Goslin 712 N. Bloomington, Streator 61364
LAWRENCE Members: 13-Dist. 8 Ruth E. Gariepy, Ex. Sec. Lawrence Cty. Mem. Hosp. Lawrenceville 62439	Alexander Po RR 4, Lawrenceville 62439	Francisco E. Martin 542 N. Main, Bridgeport 62417
LEE Members: 24-Dist. 12	Michael C.K. Hong 403 E. First St., Dixon 61021	Tiam H. Lie Rt. 5 Castellan, Dixon 61021
LIVINGSTON Members: 27-Dist. 2	Gregorio M. Manabat 612 E. Water, Pontiac 61764	Karl T. Deterding 612 E. Water, #109, Pontiac 61764
LOGAN Members: 25-Dist. 5	Steven D. Kottemann 311 8th St., Lincoln 62656	Wayne J. Schall 311 8th St., Lincoln 62656
MACON Members: 163-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur 62521	Howard L. Penning 1800 E. Lake Shore Drive, Decatur 62521	H. Gale Zacheis 2220 N. Monroe, Decatur 62526
MACOUPIN Members: 19-Dist. 6	Anand Talcherkar 116 South Plum, Carlinville 62626	Robert England 935 Morgan, Carlinville 62626
MADISON Members: 208-Dist. 6	James W. Sanders 1538 East Troy, Edwardsville 62025	Norman E. Taylor 95 S. 9th St., E. Alton 62024
MARION Members: 44-Dist. 7	Mary K. Markle 1201 E. Broadway, Centralia 62801	W. P. Plassman Box 552, Centralia 62801
MARSHALL-PUTNAM Members: 3-Dist. 2	Donald M. Gallagher Box 538, Granville 61326	Joe W. Cannon, M.D., Secretary 202 South Main, Lacon 61540
MASON Members: 5-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	Henry W. Maxfield 315 E. Chestnut, Mason City 62664
MASSAC Members: 3-Dist. 9	Enrique T. Yap 510 W. 10th St., Metropolis 62960	Benito Bajuyo P.O. Box 187, Metropolis 62960



COUNTY	PRESIDENT	SECRETARY
McDONOUGH Members: 30-Dist. 4	Edward K. Baker 505 East Grant, Macomb 61455	David Reem 505 E. Grant, Macomb 61455
McHENRY Members: 78-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Woodstock 60098	Richard Gorski 715 W. Judd, Woodstock 60098	Robert E. Stanell 3516 W. Waukegan Rd., McHenry 60050
McLEAN Members: 128-Dist. 5 Mrs. Madge Williams, Exec. Sec. 1236 E. Empire Bloomington 61701	Robert M. Reardon 1008 N. Main St., Bloomington 61701	John R. Krueger #1 Medical Hills Dr., Bloomington 61701
MERCER Members: 5-Dist. 4	Monty P. McClellan 309 NW 2nd St., Aledo 61231	Dennis D. Palmer 409 NW Fourth, Aledo 61231
MONROE Members: 10-Dist. 10	Chung Khan 112 E. Fourth St., Waterloo 62298	Edilberto Maglasang 109 W. Legion, Columbia, 62236
MONTGOMERY Members: 20-Dist. 5	Walter R. Williams 1250 East Tremont, Hillsboro 62049	Roger Wujek Medical Arts Building 1225 E. Union, Litchfield 62056
MORGAN-SCOTT Members: 50-Dist. 6	Eric Giebelhausen 2001 West Morton, Jacksonville 62650	John Peterson 400 Farmers Bank Building, Jacksonville 62650
MOULTRIE Members: 4-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951
OGLE Members: 16-Dist. 12	L. T. Koritz 324 Lincoln, Rochelle 61068	Russell Zack 915 Caron, Rochelle 61068
PEORIA Members: 419-Dist. 4 M. John Hanni, Jr., Ex. V.P. 427 1st National Bank Bldg. Peoria 61602	Gene O. Hoerr 427 1st National Bank Bldg., Peoria 61602	Frederick Heinzen 427 1st Nat'l. Bank Bldg., Peoria 61602
PERRY Members: 15-Dist. 10	Gene Stotlar 13 N. Walnut St., Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
PIATT Members: 4-Dist. 7	George Green 1111 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
PIKE Members: 11-Dist. 6	B. J. Rodriguez 868 Mortimer, Barry 62312	Carlos B. Lara 326 W. Washington, Pittsfield 62363
PULASKI Members: 1-Dist. 9	A. L. Robinson Box 277, Mounds 62964	
RANDOLPH Members: 20-Dist. 10	Allan L. Liefer 415 W. S. Fourth, Red Bud 62278	J. M. Whittenberg 1650 State St., Chester 62233
RICHLAND Members: 24-Dist. 8	Don F. Hatten 408 N. Mill St., Olney 62450	Chandra Varadachari Richland Memorial Hosp., Olney 62450
ROCK ISLAND Members: 197-Dist. 4 James A. Koch, Ex. Sec. 608 Kahl Bldg. 326 W. Third St. Davenport, Iowa 52801	Raymond F. Hillson 1520 7th Street, Moline 61265	Charles W. Koivun 1704 7th Avenue, Moline 61265

COUNTY	PRESIDENT	SECRETARY
ST. CLAIR Members: 272-Dist. 10 Ed Belz, Ex. Sec. 6400 W. Main Belleville 62223	Ronald G. Welch 333 S. Illinois, Belleville 62220	Edward P. Rose 5308 W. Main, Belleville 62223
SALINE-POPE-HARDIN Members: 32-Dist. 9	Earl E. Walker 203 N. Vine St., Harrisburg 62946	Allen G. Gerberding Prof. Arts Bldg., U.S. Rte. 45 South, Harrisburg 62946
SANGAMON Members: 402-Dist. 5 L. R. Brosi, Ex. Dir. 1 N. Old State Capitol Plaza Springfield 62701	Mir-Towfig M. Arjmand 329 S. New St., Springfield 62704	Michael C. Snyder 800 E. Carpenter, Springfield 62702
SCHUYLER Members: 4-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
SHELBY Members: 9-Dist. 7	P. D. Gurujal Shelby Cty. Med. Cntr., Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
STEPHENSON Members: 57-Dist. 12	Young Chung 1036 W. Stephenson, Freeport 61032	Ahmed Rasheed 1036 W. Stephenson, Freeport 61032
TAZEWELL Members: 75-Dist. 4 Colleen Ingersoll, Exec. Sec. P.O. Box 778 Pekin 61554	Dennis F. Olson 2808 Court, Pekin 61554	Robert F. Gregorski P.O. Box 778, Pekin 61554
UNION Members: 12-Dist. 9	Thomas W. Davis 319 S. Main St., Anna 62906	Carroll O. Loomis Union County Hosp., Main St., Anna 62906
VERMILION Members: 113-Dist. 8	Mehdi Adeli 917 N. Walnut, Danville 61832	Michael Lomax 723 N. Logan, Danville 61832
WABASH Members: 5-Dist. 9	Ernest Lowenstein 1123 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863
WARREN Members: 14-Dist. 4	Kenneth E. Ambrose 219 E. Euclid, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
WASHINGTON Members: 6-Dist. 10	Ralph Kelley 113 W. St. Louis, Nashville 62263	Charles Longwell 111 S. Washington, Nashville 62263
WAYNE Members: 9-Dist. 9	A. R. Marks 101 E. Center Rd., Fairfield 62837	Eugene B. Loftin 301 N.W. Eleventh St., Fairfield 62837
WHITE Members: 8-Dist. 9	Phillip D. Boren Doctors Clinic, Carmi 62821	P. G. Ravindranathan Doctors Clinic, Carmi 62821
WHITESIDE Members: 53-Dist. 12	Girish R. Bhatt 101 E. Miller Rd., Sterling 61081	Shashi A. Patel 1601 First Ave., Sterling 61081
WILL-GRUNDY Members: 254-Dist. 11 Ronald W. Batozech, Ex. Sec. 3033 W. Jefferson Suite 220 Joliet 60435	Kenneth Jesunas 3077 W. Jefferson, Joliet 60435	Irving Rudman 1301 Copperfield, Joliet 60435



WILLIAMSON  
Members: 38-Dist. 9

M. T. Joseph  
106 S. Vicksburg, Marion 62959

Herbert V. Fine  
110 N. Division, Carterville 62918

WINNEBAGO  
Members: 399-Dist. 12  
Robert Carlson  
Exec. Adm.  
310 N. Wyman St.  
Rockford 61101

Edward Sharp  
5668 E. State, Rockford 61108

William E. Kobler  
5670 E. State St., Rockford 61108

WOODFORD  
Members: 7-Dist. 2

Joe C. Phifer  
203 South Main, Eureka 61530

James W. Riley  
109 S. Major, Eureka 61530

#### No Organized County Society

Edwards  
Johnson  
Menard

#### Joint County Societies

Cass-Brown	Marshall-Putnam
Coles-Cumberland	Morgan-Scott
Henry-Stark	Saline-Pope-Hardin
Jefferson-Hamilton	Will-Grundy
Jersey-Calhoun	

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## Committees of the House of Delegates

### 1982 Interim Meeting

*The purpose of the Reference Committee is to consider and report to the House of Delegates its recommendations upon resolutions being considered. Reference Committees of the House of Delegates shall be appointed by the Speaker of the House as necessary. For the 1982 interim session, there will be five Reference Committees—Constitution & Bylaws, A, B, C and D. They will consider such resolutions as referred by the Speaker.*

#### COMMITTEE ON RULES & ORDER OF BUSINESS

This committee shall consider all matters regarding rules governing actions, methods and procedures, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (thirty days prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

In addition, the Committee on Rules and Order of Business must approve all resolutions submitted by individual delegates, the Resident Physician Section and the Medical Student Section in order to be considered at any interim session of the House of Delegates. Resolutions not approved by this committee will be held over for the next annual meeting.

#### COMMITTEE ON CREDENTIALS

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall

keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

#### TELLERS AND SERGEANTS AT ARMS

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

#### REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

## Illinois Delegation To The American Medical Association

The highlight of the 1982 annual meeting of the American Medical Association was Dr. Frank J. Jirka's smashing victory in his bid to become President-Elect of the AMA. With the active and vigorous support of the entire Illinois Delegation to AMA—and with the encouragement and assistance from all of ISMS—Dr. Jirka was able to defeat Dr. Lowell Steen, of Indiana, who was considered the front-runner before the meeting. Describing his campaign as “the third man in a two-man race,” Dr. Jirka was tireless in his efforts to reach all the delegates and alternates personally to seek their votes.

His campaign was masterfully run by Drs. John Ring and Clifton Reeder and by Don Udstuen, of the ISMS staff. Dr. Ring's beautiful nomination speech prior to the election was considered an important factor in the victory.

As Dr. Jirka assumes the position of President-Elect, he joins two others from Illinois heading important AMA sections—Dr. David Olive, chairman of the Resident Physicians Section, and Ronald Davis, chairman of the Medical Student Section.

It also was announced that Dr. P. John Seward, past president of ISMS, has been appointed to the Council on Legislation, bringing to four the number of AMA councils having Illinois physicians as members—Dr. Ring on the Council on Medical Service, Dr. Jack Gibbs on the Council on Medical Education, and Dr. Joseph Skom on the Council on Scientific Affairs.

Other members of the Illinois Delegation playing prominent roles at the meeting were Dr. Morgan Meyer, chairman of the Reference Committee on Constitution and Bylaws; Dr. Maynard I. Shapiro, member of Reference Committee B and Dr. Herschel Browns, member of Reference Committee H. Dr. Morris T. Friedell was a member of the Committee on Rules and Order of Business.

### **Resolution 50. ALTERNATIVE PROPOSALS FOR HEALTH PLANNING.**

This resolution asked that AMA policy support local voluntary planning with physician input, implementation by the local community, and separation of the planning process and regulatory functions. The reference committee recommended that the agency that regulates should not be the same agency that plans, stating that with the increasing emphasis on state-level activities, it is important to maintain a voluntary planning process. The resolution was amended accordingly and adopted as follows:

**RESOLVED**, That it be the policy of the American Medical Association to:

1. Support health planning on a local and voluntary basis with considerable input by physicians licensed to practice medicine in all its branches.
2. Support implementation of appropriate local health plans by the cooperative effort of the local community.
3. Support the concept that if regulatory functions should arise, they should be conducted independently of the planning process.

### **Resolution 51. INSURANCE ASSIGNMENTS.**

This resolution identifies a situation where an insured individual assigns health insurance benefits to a physician and the insurance company sends the payment to the patient instead. The resolution would have the association require the insurer to pay the physician and recover the payment from the patient. The reference committee, while sympathizing with those experiencing this problem, indicated it is aware that state courts have already decided the physicians have no legal standing in such disputes. The following substitute resolution was therefore adopted:

**RESOLVED**, That the American Medical Association investigate the frequency of erroneous payments to insurance beneficiaries instead of physicians to whom they have been assigned such payments and seek, in consultation with appropriate agencies, the minimizing or elimination of such problems.



## **Resolution 52. COCHLEAR IMPLANTS.**

This resolution was adopted on a consent calendar:

**RESOLVED**, That the American Medical Association Council on Scientific Affairs study the procedure of cochlear implants for their efficacy and safety and report back to the House of Delegates at the 1982 interim meeting.

Theodore Grevas, M.D.  
Chairman

Howard C. Burkhead, M.D.  
Secretary

## **ISMS DELEGATION TO THE AMA**

*Delegation Chairman: Theodore Grevas; Secretary: Howard C. Burkhead*

### **Delegates**

*To serve from Jan. 1, 1981 to Dec. 31, 1982  
(Elected April 15, 1980)*

David S. Fox, Chicago  
Morris T. Friedell, Chicago  
Henrietta Herbolsheimer, Chicago  
Lawrence L. Hirsch, Chicago  
Joseph R. O'Donnell, Glen Ellyn  
John J. Ring, Mundelein  
Glen E. Tomlinson, Lincoln (resigned 1982)  
George T. Wilkins, Jr., Granite City  
P. John Seward, Rockford

*To serve from January 1, 1982 to December 31, 1983  
(Elected April 7, 1981)*

Herschel Browns, Chicago  
Howard Burkhead, Evanston  
Jack Gibbs, Canton  
Theodore Grevas, Rock Island  
Morgan M. Meyer, Lombard  
Maynard I. Shapiro, Chicago  
Joseph Skom, Chicago  
Cyril C. Wiggishoff, Chicago

*To serve from Jan. 1, 1983 to Dec. 31, 1984  
(Elected April 17, 1982)*

David S. Fox, Chicago  
Morris T. Friedell, Chicago  
Henrietta Herbolsheimer, Chicago  
Lawrence L. Hirsch, Chicago  
Joseph R. O'Donnell, Glen Ellyn  
John J. Ring, Mundelein  
P. John Seward, Rockford  
George T. Wilkins, Granite City

### **Alternates**

*To serve from Jan. 1, 1981 to Dec. 31, 1982  
(Elected April 15, 1980)*

Andrew J. Brislen, Chicago  
Audley F. Connor, Jr., Chicago  
Robert P. Johnson, Springfield  
Boyd McCracken, Sr., Greenville  
Joseph Perez, Rockford  
Clifton L. Reeder, Wilmette  
Richard Rovner, Chicago

*To serve from January 1, 1982 to December 31, 1983  
(Elected April 7, 1981)*

Alfred Clementi, Arlington Heights  
Allan Goslin, Streator  
Robert C. Hamilton, Chicago  
A. Beaumont Johnson, Elgin  
Harold Lasky, Chicago  
Michael Nieder, Chicago  
Arthur Traugott, Urbana  
Ronald Welch, Belleville  
Fred Z. White, Chillicothe

*To serve from Jan. 1, 1983 to Dec. 31, 1984  
(Elected April 17, 1982)*

Andrew J. Brislen, Chicago  
Audley F. Connor, Jr., Chicago  
Robert P. Johnson, Springfield  
Alfred J. Kiessel, Decatur  
Clifton L. Reeder, Wilmette  
Harry Springer, Chicago  
Joseph Perez, Rockford

### **Honorary Members**

Walter C. Bornemeier, Saratoga, California  
Frank J. Jirka, Jr., Barrington Hills  
Burtis E. Montgomery, New York

# Resolutions for 1982 Interim Session ISMS House of Delegates

The following resolutions were received at ISMS headquarters by September 11 and, according to provisions of the bylaws, are printed in *IMJ* by title and subject. As a result of recent action by the House of Delegates, the Committee on Rules and Order of Business is responsible for recommending whether or not resolutions submitted by individual delegates will be considered by the House at an interim session or held over for the next annual meeting.

Final deadline for resolutions was October 14. At this writing, it is anticipated that other resolutions will have been submitted and accepted for consideration before that deadline. These will be included in the Delegates' Packet of materials.

<i>Number:</i>	<i>Introduced by:</i>	<i>Subject</i>
1 (I-82)	Robert P. Johnson, M.D., for the Board of Trustees	Amendments to Chapter IX. Committees
2 (I-82)	John J. Ring, M.D., for the Board of Trustees	ISMS Policy Statement on "Hospitals"
3 (I-82)	Cyril C. Wiggishoff, M.D., for the Board of Trustees	Amendment of Policy Manual Statement on "Informing the Membership"
4 (I-82)	Robert P. Johnson, M.D., for the Board of Trustees	AMA Section for Hospital Medical Staffs

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## Workshop for CME Accreditation Surveyors

Saturday, November 13, 1982

3:30-6:30 p.m.

- Update on ACCME policies and activities
- Problems encountered on site visits
- Exchange ideas and experiences

---

## Malpractice/Loss Prevention Education Program

Saturday, November 13, 1982

3:30-5:30 p.m.

*"Medical Malpractice: Is there still a problem? What was the effect of changes in the law? How must physicians act now?"*

*Donald W. Aaronson, M.D., J.D.*

*"Prospective legislative change and a review of the current political climate"*

*Donald A. Udstuen*

**This program carries 2 hours Category 2 CME credit.**

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*ILLINOIS STATE MEDICAL SOCIETY*

## SCHEDULE OF MEETINGS

Sheraton-St. Louis

### Interim Session, House of Delegates November 13-14

#### Friday, November 12

9:00 a.m. - ISMS Board of Trustees Meeting  
10:00 p.m.

1:30 p.m. Reference Committee Meetings

3:30 p.m. - Loss Prevention Education  
5:30 p.m. Program

3:30 p.m. - CME Site Surveyors Workshop  
6:30 p.m.

#### Saturday, November 13

7:30 a.m. Rules and Order of Business  
Meeting

8:00 a.m. ISMS Board of Trustees Meeting

8:00 a.m. - ISMS Delegate Registration  
5:00 p.m.

8:30 a.m. Reference Committee Personnel  
Meeting

8:30 a.m. House of Delegates Credentials  
Committee

9:30 a.m. ISMS House of Delegates

10:00 a.m. Presentation by 1983 AMA  
President-Elect Candidate

10:15 a.m. Professional Liability Insurance  
Alternatives Slide Presentation

10:45 a.m. - District Meetings  
1:30 p.m.

11:30 a.m. - ISMS Delegates' Buffet  
1:00 p.m.

3:30 p.m. - Medical Discipline and  
4:30 p.m. Mandatory Reporting Seminar

5:30 p.m. - Political Action Meeting  
6:30 p.m.

#### Sunday, November 14

8:00 a.m. Board of Trustees Breakfast  
Meeting

8:00 a.m. ISMS Registration

9:00 a.m. House of Delegates Credentials  
Committee

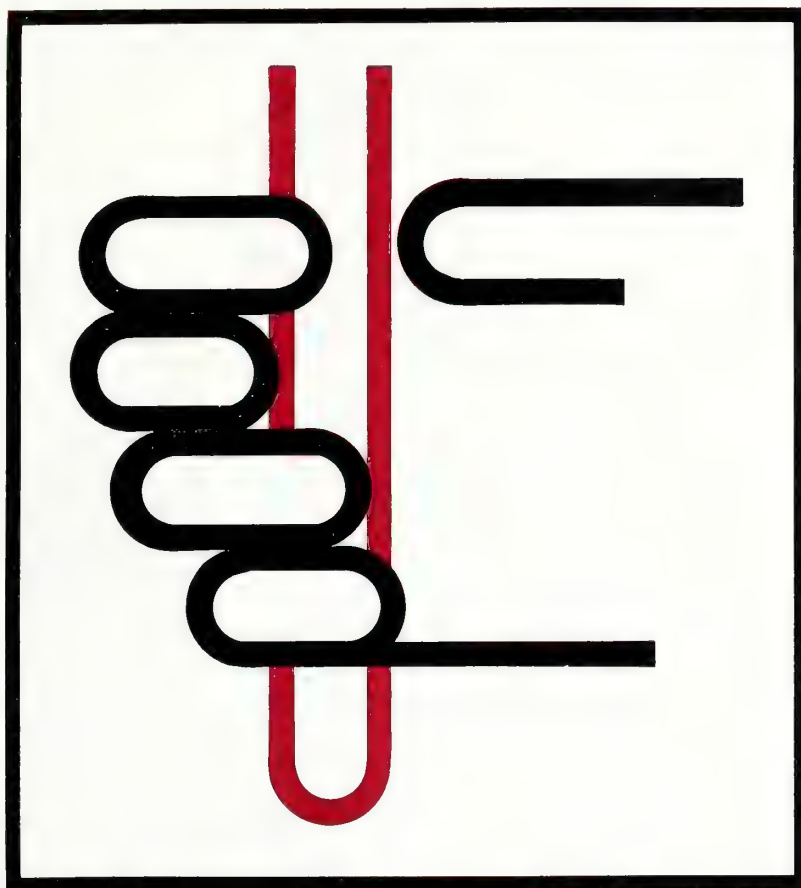
9:30 a.m. ISMS House of Delegates

9:45 a.m. Presentation by 1983 AMA  
President-Elect Candidate

Immediately AMA Delegation meeting  
following  
close of  
House of  
Delegates

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## Unmatched range of indications

In both office and hospital practice, only Valium (diazepam/Roche) does so much so well. One reason: Valium can claim not only clinically useful "mind and muscle" effects but anticonvulsant properties as well. The most versatile of the benzodiazepines, Valium is most widely known as a dependable anxiolytic, producing prompt relief of excessive anxiety, whether seen alone or associated with functional or organic disorders. In addition, adjunctive Valium is often an important asset in programs designed to relieve skeletal muscle spasm due to local pathology or to control certain seizure disorders.

Valium fits well into most therapeutic regimens because it is used with many primary medications, such as cardiac glycosides, diuretics, antacids, vasodilators and anticoagulants. The clearance of Valium and certain other benzodiazepines can be delayed by cimetidine administration, but the clinical significance of this is unclear. Patients should be cautioned against drinking alcohol, driving or operating machinery while taking Valium, as with all agents that act on the CNS. Periodic reassessment of the usefulness of continued therapy with Valium is recommended.

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ROCHE



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Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication. Abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anti-convulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**How Supplied:** For oral administration, Valium scored tablets—2 mg, white, 5 mg, yellow, 10 mg, blue—bottles of 100\* and 500,\* Prescription Paks of 50, available in trays of 10\* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10\*.

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†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110.

## Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style and order: Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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1. Promoting Health/Preventing Disease: Objectives for the Nation U.S. Department of Health and Human Services, November 1980

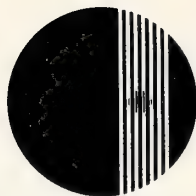
\*An in vitro simulation of gastric ulcer acid level conditions based on standard laboratory methodology. Data on file. Ayerst Laboratories  
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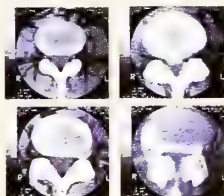


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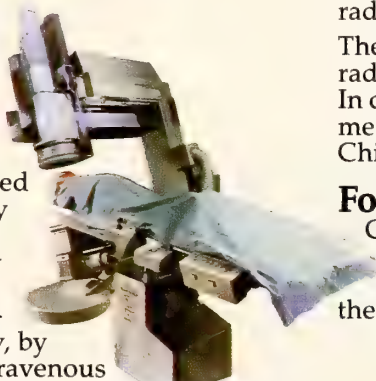
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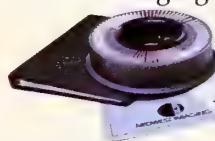
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# Viewbox

(Continued from page 242)

## Diagnosis: Acetabular Fracture. Computed Tomography



Figure 2

CT of patient in Figure 1. Fracture of right posterior acetabulum (arrow). Left hip—normal anterior column (A), posterior column (P), and quadrilateral plate (Q).

In Figure 1 there is a thin fragment of bone projected lateral to and paralleling the posterior rim of the acetabulum.

The computed tomogram (Figure 2) more clearly demonstrates a fracture of the posterior rim of the acetabulum. In addition, periarticular soft tissue swelling, and a small intrapelvic hematoma, are demonstrated.

Nuclear medicine studies may not demonstrate a fracture acutely, and would not demonstrate the anatomic relationships. Nuclear medicine studies are valuable in demonstrating late avascular necrosis following femoral head fractures or dislocation.

Plain tomograms are useful in demonstrating acetabular pathology but may not clearly demonstrate anatomic relationships, and can pose problems with patient positioning. They do not demonstrate soft tissue pathology and can miss subtleties.

Arthrography is accurate in locating loose bodies in the joint but most articular damage is caused by bone-containing loose bodies which can be reliably demonstrated non-invasively with computed tomography.

## Acetabular Fractures

The acetabulum is a shallow cup of bone, open for approximately 40° on its inferior aspect, and lodged between two columns of bone which approximate above it and diverge inferiorly. The anterior (iliopubic) column runs medially, anteriorly and inferiorly from the iliac crest to the pubic symphysis. The posterior (ilioischial) column runs from the inferior SI joint and sciatic notch to the ischial tuberosity. The two columns unite just about the mid point of the anterior column<sup>1</sup> and their apex is capped by a wedge of compact bone which forms the roof of the acetabulum.<sup>1</sup>

The medial or pelvic wall of the acetabulum is formed by a thin plate of bone (quadrilateral plate) joining the two columns (Figure 2).<sup>2</sup> The major weight bearing portion of the acetabulum is the superior posterior dome which is also the wedge of bone at the apex of the converging columns.<sup>3</sup>

## Mechanism of Injury

The mechanism of injury is generally a direct blow to the area of the greater trochanter,<sup>4</sup> or a blow to the knee, such as hitting a dashboard. If the knee is internally rotated and the hip flexed, a posterior dislocation and fracture can occur. If the thigh is abducted, a blow to the knee causes further abduction and external rotation, causing an anterior dislocation.<sup>5</sup> In addition an antero-posterior crush to the pelvis can also cause the injury.<sup>6</sup> Thus, if the force is directed towards the greater trochanter directly or there is a crush, there may not be a posterior dislocation, but a central one is certainly possible.

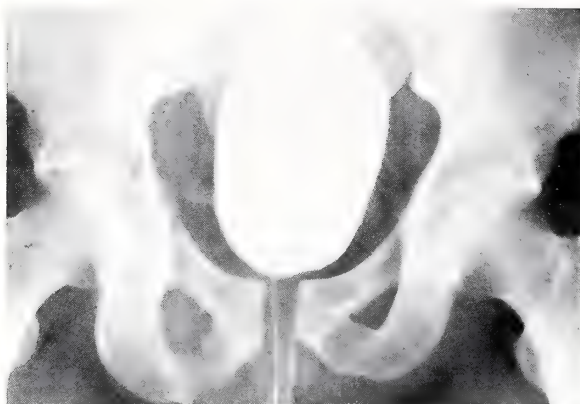
## Classification

There are several classifications of acetabular fractures. Epstein did not use the above described anatomic description. His classification, based on 559 femoral head dislocations, 10% of which were anterior, is as follows:

*Type I:* with or without minor fracture; *Type II:* with single large fracture of posterior rim; *Type III:* with comminuted fracture of rim, with or without major fragment; *Type IV:* with fracture of acetabular rim and floor; *Type V:* with fracture of femoral neck.<sup>5</sup>

Other classifications are based on the anatomic columns of the acetabulum. Letournel, using a series of 641 fractures and/or dislocations, observed the following patterns.





**Figure 3**  
AP pelvis



**Figure 4**  
45° oblique pelvis.

The opacified urinary bladder is deviated to the left by a hematoma. There are fractures of the right acetabulum, pubis, and ischium. The ischial and pubic fractures are better demonstrated in the oblique view (Figure 4).

#### (A) Simple fractures

- (1) Fractures posterior wall of acetabulum (23%)
  - (a) 80% simple separation
  - (b) 20% marginal impaction of the inner portion of the posterior wall
- (2) Fracture posterior column, usually 1 fragment (6%)
- (3) Anterior wall fracture (2%)
- (4) Anterior column fracture (4%)
- (5) Pure transverse fracture through acetabulum (9%)

#### (B) Complex fractures

- (1) T-shaped, transverse fracture plus split of the ischio pubic fragment (7%)
- (2) Posterior column and wall (3%)
- (3) Transverse and posterior wall (21%)
- (4) Anterior and hemitransverse (6%)
- (5) Bicolumnar (21%)<sup>1</sup>

Again, as in Epstein's classifications,<sup>1</sup> posterior dislocations and associated posterior and central injuries form the bulk of the fractures. Pennal, *et al.*, further simplified the above into:

- (1) Single column fracture
  - (a) anterior
  - (b) posterior
- (2) Two column fracture
  - (a) transverse
  - (b) oblique
  - (c) t-shaped

With the addition of two modifiers:

- (a) displacement,
- (b) comminution.<sup>6</sup>

Thus, acetabular injuries are usually coupled with femoral head dislocations.

#### Associated Injuries

The reported frequency of associated injuries is variable. According to Harris,<sup>7</sup> acetabular injuries are rarely associated with urinary tract damage. Intrapelvic hemorrhage of variable amount occurs with almost all, and sciatic nerve injury occurs in about 1/6. In Pennal's series, about one-half had additional injuries which were "frequently" related to the acetabular fracture.<sup>6</sup> Murr, *et al.*, reported about 1/5 associated abdominal injuries with acetabular fracture.<sup>8</sup> Pearson and Hargadon reported 4/33 with abdominal injury and 6/33 with head injury.<sup>4</sup> Epstein reported 194/559 with multiple injuries, type unspecified, with 13 fatalities.<sup>5</sup>

#### Management and Complications of Injury

The goal of management of the fractured acetabulum is to restore integrity of the articular surface, and leave an innominate bone and acetabulum as close to their pre-injury state as possible.<sup>1</sup>

Open reduction and reconstruction is recommended except when there is no displacement<sup>9</sup> and Epstein recommends surgical repair on all but Type I fractures of his classification.<sup>5</sup>

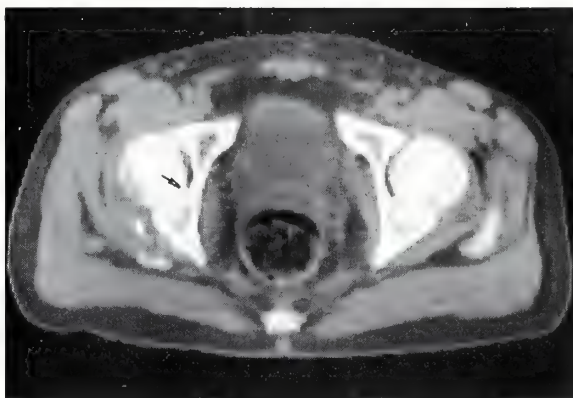
#### Prognosis

Pennal observed 30% incidence of degenerative joint disease when there is no pelvic displacement or dome damage.<sup>6</sup> Epstein observed an 18% incidence of avascular necrosis and 35% incidence of traumatic arthritis which decreased to 5.3% and 17% in patients treated by primary open reduction. Removal of articular debris was felt to be an important factor in decreasing traumatic



**Figure 5**  
AP pelvis

Following reduction of a posterior hip dislocation the patient had persistent pain. A loose body (arrow) of the right hip seen on CT study (Figure 6) cannot be identified in Figure 5 radiograph. The acetabular fracture is visible in both figures.



**Figure 6**  
Computed tomography right hip.

arthritis. There was a 10% rate of sciatic or peroneal nerve injury, two-thirds of which resolved by 30 months.<sup>5</sup> Letournel reported 8.4% nerve palsy, 23% aseptic necrosis and 10% osteoarthritis.<sup>1</sup>

### Radiographs

Four radiographic views of the pelvis are needed to define traumatic anatomy of the acetabulum. These are (1) standard pelvis, AP view; (2) AP view centered on affected hip; (3) obturator oblique view, patient supine and rolled 45° away from side of injury (Figure 4) and (4) iliac oblique view, patient supine and rolled 45° toward side of injury.

The axial view provided by CT most clearly demonstrates the relationship of the columns to the acetabulum and other pelvic structures.

### Computed Tomography

There are several problems with conventional radiography in the evaluation of acetabular fractures. The first of these is the difficulty in positioning an injured patient to perform a complete examination. Sometimes a single AP radiogram must suffice.

Pearson and Hargadon had an initial false positive rate for acetabular fracture of 22%.<sup>4</sup> Rogers, *et al.*, demonstrated how difficult central fractures of the acetabulum can be to detect, especially on the AP film.<sup>10</sup> They frequently found it necessary

to use either posterior oblique films or linear tomography. It is difficult to move an injured patient to get several views. In Haley's series of 26 patients, a full examination was completed in nine, AP and oblique views in eight, and single AP films in nine. CT was completed in all 26.<sup>2</sup> Sauser, *et al.*, fared slightly better, completing 12/13 conventional studies.<sup>11</sup>



**Figure 7**  
Computed tomography of acetabulum.  
There is a fracture of the anterior column and quadrilateral plate (arrows). A hematoma displaces the gas filled rectum (R) to the left. The quadrilateral plate fracture could not be identified on plain radiographs.



Harley and Mack were able to do AP films only in 34%. Thirty-two percent of their patients had two views, and only 34% had a complete three view examination.<sup>2</sup> They analyzed their data and found the following: CT was no better than conventional radiography in detecting fractures of the iliac wing, anterior and posterior pelvic columns and the pubic rami. CT was more sensitive in detecting fractures of the sacrum, quadrilateral plate, acetabular roof and posterior acetabular lip. In addition, CT was better at revealing loose bodies in the joint space, which if not removed are a significant source of subsequent joint damage (Figures 5-7). They also found CT superior in defining the stable fragment, or that portion of the pelvis attached to the axial skeleton. This information is very important in guiding open reduction and internal fixation to prevent the fixation of one nonstable fragment to another.

Computed tomography can provide a clear demonstration of the acetabular anatomy which will help to determine if surgery is needed. If surgery is indicated, CT will allow for better pre-operative planning. CT can identify subtle fractures and bone containing loose bodies.

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# Case Reports

## Report of Two Cases

### Tuberculous Enteritis in East Central Illinois

BY JULIUS C. BONELLO, M.D./URBANA

*Intestinal tuberculosis was once the most common complication of active pulmonary T.B. Prior to the development of effective antituberculosis drugs, autopsy studies showed that 80% of patients with pulmonary disease had tuberculous enteritis.<sup>1</sup> Fortunately, it is rare today in the United States. We had not seen a case of primary gastrointestinal tuberculous enteritis or enteritis associated with pulmonary infection in 25 years until May of this year when two patients were treated. This paper reviews our experience with these two patients.*

#### Case Report #1

The patient, a 62-year-old, retired oil field worker, presented with a three month history of cough, hemoptysis, and upper lobe infiltrates seen on chest X-ray. He had served in the military in Germany in 1944-45, and recalled no prior tuberculin test. Approximately two months prior to admission, he developed hoarseness and one week later, a cough with hemoptysis. The patient had a 60 pack per year history of smoking. He denied any chest pain, chills, fevers, night sweats, weight loss, or exposure to TB.

Our impression was bilateral fibronodular lung disease with cough, hemoptysis, and hoarseness. The patient was seen in otolaryngologic consultation, where TB laryngitis was diagnosed. He was started on triple drug therapy of INH, Rifam-

pin,<sup>®</sup> and Ethambutol.<sup>®</sup>

The patient returned ten days later complaining of periumbilical pain associated with nausea and vomiting. On examination, his abdomen was tender and markedly distended with decreased but present bowel sounds. A KUB showed a pattern consistent with a partial small bowel obstruction. The patient was admitted to the hospital and underwent a colon X-ray, which was grossly normal, without visualizing the terminal ileum. The patient underwent serial KUBs over the next 24 hours which showed a pattern consistent with complete small bowel obstruction. The patient was brought to surgery. A 10cm. stricture of the terminal ileum, resulting in a small bowel obstruction was found. The cecum was also thickened, but not so much as the terminal ileum. A resection of the

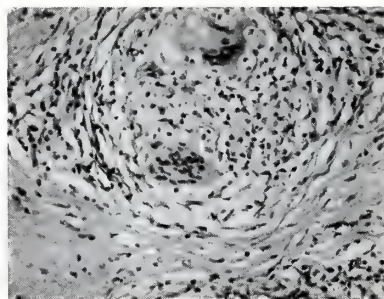


Figure 1  
Hematoxylin and Eosin

terminal ileum and cecum was performed with a primary anastomosis. The patient's postoperative course was benign, and he was discharged on the tenth postoperative day.

Final pathologic report showed segments of ileum markedly thickened and diffusely infiltrated with fairly dense fibrous tissue and chronic inflammatory cells, including innumerable small granulomas and numerous Langhans' giant cells. The mucosa was focally ulcerated and covered with exudate. The tubercles were vaguely necrotic, but no distinct caseation necrosis was seen. (Figure 1) Acid-fast stains were positive for pathogenic bacilli. Two weeks after the patient left the hospital, sputum cultures came back positive for M. tuberculosis.



**Julius C. Bonello, M.D.**, is a board certified colon and rectal surgeon affiliated with the Carle Clinic in Urbana. An assistant professor of clinical surgery at the UI School of Medicine, he is a member of the American Society of Colon and Rectal Surgeons and the American Association for the History of Medicine.

#### Case Report #2

A 36-year-old electrician pre-



sented with a five-month history of severe periumbilical cramps associated with a 26 pound weight loss. The patient gave a history of episodic and nocturnal diarrhea of up to twelve stools a day.

On examination he was a thin, white male, who appeared chronically ill. The physical exam revealed tenderness in the right lower quadrant with fullness which was confirmed by rectal exam.

Our impression was a partial bowel obstruction, probably secondary to Crohn's ileocolitis.

The patient was hospitalized and underwent a sonogram of the abdomen and a small bowel X-ray, both of which were negative. At colonoscopy, granulation tissue was present on the ileocecal valve. This was biopsied and returned severe, nonspecific chronic colitis. The patient was given a preliminary diagnosis of Crohn's ileocolitis and started on Azulfidine® and Konsyl®.

He returned four months later, still complaining of crampy right lower quadrant pain with diarrhea. The patient had gained approximately ten pounds. On physical exam, he still had right lower quadrant tenderness with fullness. Rectal exam showed 2+ guaiac positive stool. Following colon and rectal surgery consultation, with the tentative diagnosis of Crohn's disease, the patient was scheduled for surgery. A large inflammatory mass with associated adhesions was found involving the terminal ileum, appendix, cecum, and ascending colon. This entire mass was removed and a primary anastomosis was performed. The patient's postoperative course was benign and he was discharged on the twelfth postoperative day. The patient is now 12 months post-op and has returned to his normal preoperative weight.

The final pathologic report revealed a 11cm. stricture in a 35cm. portion of small bowel, which was filled with multiple granulomas with minimal necrosis and no caseation. Multi-nucleated giant cells were also present. Lymphoid follicles were distributed throughout the entire thickness of the bowel and fluorescent stains for tuberculin organisms were positive. Tissue cultures returned positive for *M. fortuitum*.

## Discussion

Most physicians regard tuberculosis as the devastating "white plague" of previous generations. Once one of the leading causes of death in the United States, today only sporadic cases are detected, usually in cities with large immigrant populations. However, incidence has recently shown a slight but significant rise. The Center for Disease Control reported a 1980 increase of .3% in actual cases.<sup>2</sup> This increase stands in contrast to the usual 4% decrease a year noted since 1953, when records were first kept. Although the state of Illinois recorded a drop in TB cases from 1,540 in 1979 to 1,352 in 1980, Illinois ranks twenty-second among all states in number of cases reported.

The association of pulmonary TB and bowel disease has been noted throughout medical history. Hippocrates wrote in his Aphorisms: "diarrhea attacking a patient affected with phthisis is a mortal symptom." Laennec noted the association between cavitary lung disease and lesions in the terminal ileum. In 1911, Steirlin was one of the first to describe the radiologic manifestations of TB enteritis.<sup>3</sup>

Tuberculous enteritis results from swallowed live tubercle bacilli, usually *M. tuberculosis* or *M. bovis*. Occasionally, as in our case #2, one of the rare "anonymous" mycobacteria will be the etiologic agent. Once swallowed, the organism invades the mucosa and sets up foci of infection in the submucosa and lymphatic tissue. Although the entire GI tract is a potential harbor for the disease, the ileocecal region is the site of 85-90% of infections.<sup>4</sup> Tandon and Prakash state that this region is thought to be involved most often because infection occurs in "(1) areas of increased physiologic stasis, (2) regions of most abundant lymphoid tissue, (3) areas of increased rate of absorption and (4) areas where small bowel contents are most completely digested, permitting closer contact of acid fast bacillus with the mucosal surface."<sup>5</sup>

Once invaded, three types of lesions occur—the hypertrophic (Case 2); the ulcerative form which is the most common and associated with active lung disease; and the ulcerohypertrophic form (Case 1).<sup>5</sup> All of these lesions consist of caseating

granuloma with acid-fast bacilli, the pathognomonic histologic lesion.

Symptoms associated with TB enteritis include crampy abdominal pain with diarrhea and weight loss. Fever, night sweats, and a right lower quadrant mass may be present. In patients without active pulmonary disease (50%), the diagnosis may be difficult but the workup should be all inclusive as for any GI malady.<sup>6</sup> Stool cultures positive for pathogenic mycobacteria are not proof of the disease. In patients with active pulmonary disease, the diagnosis may be difficult, due to gastrointestinal side effects of antituberculosis drugs. However, contrast studies should be helpful but not definitive, since carcinoma, lymphoma and Crohn's disease mimic the disease radiographically.<sup>7</sup> Final proof rests with the histologic demonstration of caseating granulomata with acid fast bacilli.

Medical treatment alone will suffice in about 50% of patients with TB enteritis, generally those with the ulcerative form, reserving surgical intervention for complications such as fistula formation, hemorrhage, perforation, and obstruction.<sup>8</sup> Stricture formation is also an indication because radiographically the disease cannot be distinguished from carcinoma.

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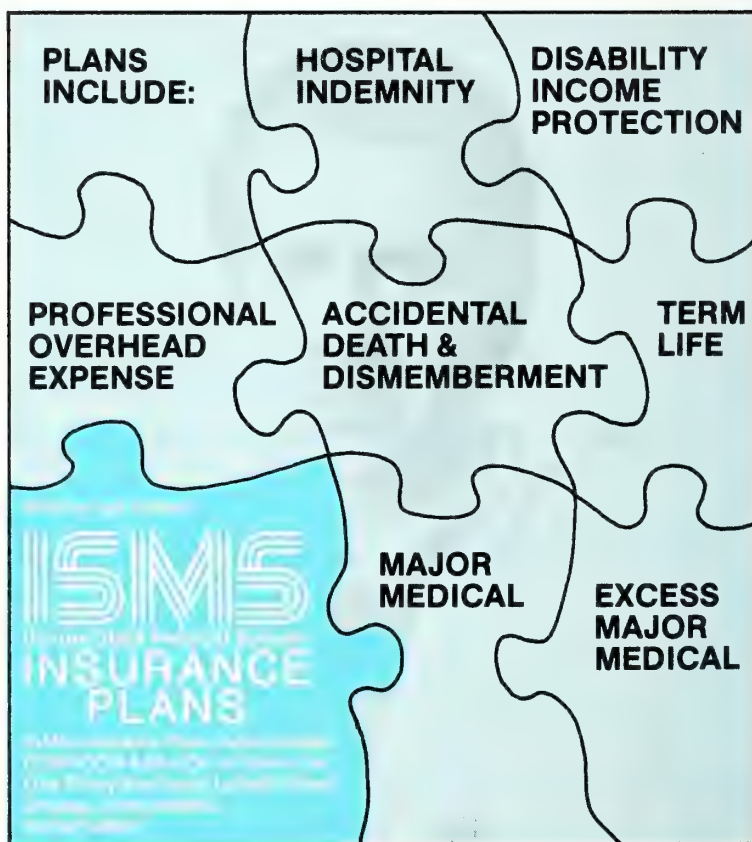
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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

## NOVEMBER

### Clinical Allergy for the Practicing Physician

**For:** MD's. Symposium, Nov. 18-20, St. Louis, MO. **Sponsor:** Washington University School of Medicine, CME, Box 8063, 660 S. Euclid St., St. Louis, MO 63110. **Reg. deadline:** none. **Fee:** \$225. **Reg. limit:** 150. **Credit:** Category 1, 19½ hours; AAFP Prescribed, 19½ hours; AOA, 19½ hours. **Contact:** Loretta Giacomello. **Phone:** 314/454-3873.

### Allergy

### Cardiac Rehabilitation

**For:** GP's, FP's, Internists. Seminar, Nov. 5-6, Hyatt Lincolnwood, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Drive E., Englewood, CO 80112. **Reg. deadline:** none. **Fee:** \$245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **Contact:** Doris Price. **Phone:** 800/525-8651 x 123.

### Cardiology

### Emergency Department Management

**For:** MD's. Symposium, Nov. 18-19, Springfield. **Sponsor:** SIU School of Medicine, P.O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Emergency Care

### Family Medicine

**Diagnosis & Management of the Acute Cardiac Patient**  
**For:** FP's. Lecture, Nov. 3-5, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$250. **Reg. limit:** 80. **Credit:** Category 1, 20 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Family Medicine

### Pain

**For:** MD's. Lecture, Nov. 17, 12:30 p.m., Hyatt Hotel, Oak Brook. **Sponsor:** DuPage County Medical Society, 800 Roosevelt Rd., Bldg. 8, Rm. 300, Glen Ellyn 60137. **Reg. deadline:** 11/12. **Fee:** none. **Credit:** Category 1, 4 hours. **Contact:** Lillian Widmer. **Phone:** 312/858-9603.

### Internal Medicine

### Cardiovascular Disease

**For:** MD's. Seminar, 8:00 a.m., Nov. 3, Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan. **Fee:** \$5. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312/578-2555.

### Malignant Disease

### Oncology Symposium

**For:** MD's. Symposium, Nov. 17, 1:00 p.m., Marion. **Sponsor:** SIU School of Medicine, P.O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Advances in Internal Medicine

**For:** Internists. Lecture, Nov. 15-19, Chicago. **Speaker:** Sheldon Waldstein, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Credit:** Category 1, 35 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### OB/GYN Seminar-at-Sea

**For:** MD's. Symposium/Cruise, Nov. 27-Dec. 7, Caribbean. **Sponsor:** SIU School of Medicine, P.O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 48 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Hysteroscopy Workshop, Contact & Panoramic

**For:** Ob/Gyn. Lecture, Nov. 19-20, Chicago. **Sponsor:** Northwestern University Medical School, CME, 301 E. Chicago Ave., Chicago 60611. **Reg. fee:** \$275. **Credit:** Category 1, 9 hours. **Contact:** Paula Puntenney. **Phone:** 312/649-8533.

### Basic and Clinical Review

**For:** MD's. Symposium, Nov. 26-30, Dearborn, MI. **Sponsor:** Wayne State University School of Medicine, CME, 4201 St. Antoine, 4H UHC, Detroit, MI 48201. **Fee:** \$450. **Reg. limit:** none. **Credit:** Category 1, 44 hours. **Contact:** Gerald Prieur, Jr. **Phone:** 313/577-1180.

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**For:** Pathologists. Workshop, Nov. 13, Marriott Hotel O'Hare, Chicago. **Sponsor:** The Chicago Pathology Society, c/o Marshall Short, MD, Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Fee:** \$45. **Reg. limit:** none. **Credit:** Category 1, 6 hours. **Contact:** Marshall Short, MD. **Phone:** 312/626-4300 x 383.

### Practical Pharmacology

**For:** MD's. Symposium, Nov. 9, 7:00 p.m., Effingham. **Sponsor:** SIU School of Medicine, P.O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 3 hours; AAFP Prescribed, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Plastic Surgery

### Management of Upper Extremity Injuries

**For:** MD's. Symposium, Nov. 12-13, St. Louis, MO. **Sponsor:** Washington University School of Medicine, CME, Box 8063, 660 S. Euclid St., St. Louis, MO 63110. **Reg. deadline:** none. **Fee:** \$150. **Reg. limit:** 150. **Credit:** AAFP Prescribed, 13 hours; Category 1, 13 hours; AOA, 13 hours. **Contact:** Loretta Giacomello. **Phone:** 314/454-3873.

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### Contemporary Topics in Psychiatry

**For:** Psychiatrists, Neurologists. Lecture, Nov. 8-12, Chicago. **Speaker:** Francois Alouf, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$375. **Reg. limit:** 85. **Credit:** Category 1, 42 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

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### Office & Hospital Treatment of Chemical Dependence

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### Rheumatology

### Purine Metabolism

**For:** MD's. Lecture, Nov. 8, 9:00 a.m., North Chicago. **Speaker:** B. Rothschild, MD. **Sponsor:** Dept. of Rheumatology, UHS/CMS, 3333 Green Bay Rd., North Chicago. **Fee:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

### Rheumatology

### Endorphins

**For:** MD's. Lecture, Nov. 22, 9:00 a.m., North Chicago. **Speaker:** Seymour Ehrenpreis, PhD. **Sponsor:** Dept. of Rheumatology, UHS/CMS, 3333 Green Bay Rd., North Chicago. **Fee:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

### Sports Medicine

### Athletic Injuries

**For:** MD's. Symposium, Nov. 3, 1:00 p.m., Alton. **Sponsor:** SIU School of Medicine, P.O. Box 3926, CME, Springfield 62708. **Reg. deadline:** yes. **Fee:** yes. **Reg. limits:** none. **Credit:** Category 1, 4 hours; AAFP Prescribed, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Surgery

### Flexible Fiberoptic Sigmoidoscopy

**For:** Surgeons. Lecture, Nov. 20, Chicago. **Speaker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$125. **Reg. limit:** 60. **Credit:** Category 1, 7 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

## DECEMBER

## JANUARY

### Advanced Peripheral Vascular Surgery

**For:** Peripheral Vascular Surgeons. **Lecture,** Nov. 29-Dec. 3, Chicago. **Speaker:** D. Preston Flanigan, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Reg. limit:** 80. **Credit:** Category 1, 34 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

### Fiberoptic Esophagogastroduodenoscopy

**For:** Surgeons, Internists, Gastroenterologists. **Lecture,** Nov. 15-17, Chicago. **Speaker:** C. Thomas Bombeck, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Burns

**For:** MD's. **Symposium,** Nov. 11, 1:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, P.O. Box 3926, CME, Springfield 62703. **Reg. deadline:** yes. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **AAPF Prescribed,** 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Terminal Illness

### Hospice

**For:** MD's. **Lecture,** Nov. 5, 8:00 a.m., Chicago. **Speaker:** Sheldon Burchman, MD. **Sponsor:** Grant Hospital, CME, 550 W. Webster Ave., Chicago 60614. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Sharon Smith. **Phone:** 312/883-2112.

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## Internal Medicine

### Lake County Medical Surgical Seminar

**For:** MD's. **Seminar,** 8:00 a.m., Dec. 15, Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan 60085. **Reg. deadline:** 12/13. **Fee:** \$5. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312/578-2555.

## Neurology

### Neurology for the Non-Neurologist

**For:** Internists, FP's, Psychiatrists. **Course,** Dec. 8-10, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, CME, 600 S. Paulina, Chicago 60612. **Reg. deadline:** none. **Fee:** \$350. **Reg. limit:** none. **Credit:** Category 1, 20 hours. **Contact:** Barbara Trejo. **Phone:** 312/942-7095.

## OB/GYN

### Advanced Colposcopy

**For:** Ob/Gyn. **Course,** December 3-4, Chicago. **Sponsor:** Northwestern University Medical School, CME, 301 E. Chicago Ave., Chicago 60611. **Reg. fee:** \$290. **Credit:** Category 1, 12 hours. **Contact:** Paula Puntney. **Phone:** 312/649-8533.

## Pathology

### Male Infertility

**For:** Pathologists. **Lecture,** Dec. 13, 7:30 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Marshall Short, MD, Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, MD. **Phone:** 312/626-4300 x 383.

## Pathology

### Liver & GI Clinico-Pathologic Conference

**For:** MD's. **Lecture,** Dec. 27, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Rheumatology

### Fibrinolysis

**For:** MD's. **Lecture,** 9:00 a.m., Dec. 6, North Chicago. **Speaker:** Nicholas Joyce-Clarke, MD. **Sponsor:** Dept. of Rheumatology, UHS/CMS, 3333 Green Bay Rd., North Chicago. **Fee:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Rheumatology

### Cyclic Nucleotides

**For:** MD's. **Lecture,** 9:00 a.m., Dec. 20, North Chicago. **Speaker:** Ira Fenton, DO. **Sponsor:** Dept. of Rheumatology, UHS/CMS, 3333 Green Bay Rd., North Chicago. **Fee:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Headache

### Diagnosis & Treatment of Headache

**For:** MD's, DO's. **Workshop,** Jan. 13-15, Marriott's Camelback Inn, Scottsdale, AZ. **Sponsor:** American Association for the Study of Headache, 5252 N. Western Ave., Chicago 60625. **Reg. deadline:** 11/10. **Fee:** \$275. **Reg. limit:** 300. **Credit:** Category 1, 15 hours; AAPF Prescribed, 15 hours; AOA, 2-D. **Contact:** Seymour Diamond.

## Internal Medicine

### The Year in Internal Medicine

**For:** Internists, FP's, GP's. **Lecture,** Jan. 26-29, Chicago. **Sponsor:** Northwestern University Medical School, CME, 301 E. Chicago Ave., Chicago 60611. **Reg. fee:** \$200. **Credit:** Category 1, 20 hours. **Contact:** Paula Puntney. **Phone:** 312/649-8533.

## Pathology

### Liver & GI Clinico-Pathologic Conference

**For:** MD's. **Lecture,** Jan. 25, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Pathology

### Biochemical Evaluation of Pancreatic Disease

**For:** Pathologists. **Lecture,** Jan. 10, 7:30 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Marshall Short, MD, Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, MD. **Phone:** 312/626-4300 x 383.

## Urology

### Genitourinary Pathology

**For:** Urologists. **Course,** Jan. 27-30, Airport Marriott, St. Louis, MO. **Sponsor:** American Urological Assn., P. O. Box 25147, Houston, TX 77265. **Reg. deadline:** 1/27. **Fee:** \$230, member; \$260, non-member. **Reg. limit:** 150. **Credit:** Category 1, 16 hours. **Contact:** Alice Henderson. **Phone:** 713/790-6070.

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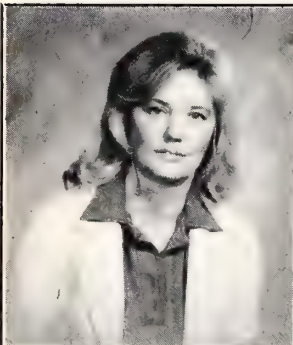
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# Illinois Society, American Association of Medical Assistants

## Message to Physicians

Illinois Society extends to you, your medical assistant and your family, an invitation to attend a regular monthly meeting of the local chapter in your area. A phone call to the president listed below will provide you with the date, time, place of meeting, topic and name of the speaker.

*Aux Plains*—Corrine Berg, 312-455-5524; *Chicago*—Pauline Becker, CMA, 312-671-3389; *Cook South*—Marion Martino, 312-597-6819; *Northwest Cook*—Arlene Brown, 312-438-7240; *Southwest Suburban*—Dora Baker, 312-448-0843; *West Cook*—Lesa Greene, CMA-A, CMA-C, 312-453-6733; *Coles Cumberland*—Nancy Weddell, 618-455-3281; *De Kalb*—Connie Clanner, 815-895-4605; *Du Page*—LaVeda Davis, 312-620-0698; *LaSalle*—Holly Morrow, 815-223-4117; *Macon*—Irene Borders, CMA, 217-875-0588; *McLean*—Janet Rivero, CMA, 217-732-6111; *Peoria*—Margo Carey, 309-243-7117; *Randolph*—Faye A. Magers, 618-826-3129; *Rock Island*—Rebecca Cruse, 309-792-0707; *Spoon River Valley*—Catherine Champlin, 309-647-6780; *St. Clair*—Minnie Lebowitz, 618-344-4667; *Vermilion*—Cheryl Smiley, CMA, 217-267-3614; *Will Grundy*—Heidi Stadelmaier, CMA, 815-886-9150; *Winnebago*—Linda Marie Curtis, CMA, 815-389-4039.

The local chapter attempts to provide: (1) continuing education to improve the knowledge and skill of medical assistants for the benefit of employers and patients; (2) a means of communication between members and the state and national organizations; (3) an opportunity for medical assistants to participate in the association's services and activities, and (4) assistance in seeking individual goals and meeting personal fellowship needs.

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of the evening might be one of your colleagues.

We have the endorsement of AMA, Illinois State Medical Society as well as the local medical society. May we expect to see you or your medical assistant at one of our meetings?

Information regarding Illinois Society, AAMA, may be obtained from Janet Binkowski, RN, president, 428 Adams Street, Dolton, IL 60419 or Ruby Jackson, CMA, chairman, Public Relations Committee, 7337 South Shore Dr. #625, Chicago, IL 60649. ◀

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# Surgical Grand Rounds

JOHN M. BEAL, M.D. AND JULIUS CONN, JR., M.D., CONTRIBUTING EDITORS

*Surgical Grand Rounds are held weekly on Tuesday, 5:00 pm in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 25, 1981.*

## Zenker's Diverticulum

**Dr. Joseph Casey:** An 86-year-old white male was admitted with a three year history of dysphagia. He reported a sensation of food "sticking" in his throat and fullness in his neck during and after eating. By moving his head and tightening his neck muscles, he could regurgitate and relieve this problem. Just prior to admission, he used this maneuver before going to bed, so that he would not regurgitate while sleeping. He denied other gastrointestinal symptoms. His past medical history included a bowel resection for cecal carcinoma five years earlier, a transurethral resection for benign prostatic hypertrophy 15 years earlier, and a left inguinal hernia repair. He was not receiving any medication.

His physical examination revealed normal vital signs; he was mentally alert. Cervical adenopathy was absent and the trachea was in the midline. The physical examination was otherwise unremarkable. His laboratory data, including hemogram, SMA-20, coagulation profile and urinalysis were within normal limits. Chest X-ray and EKG were also normal. A barium study of the esophagus was performed.

**Dr. Gary Dillehay:** An esophagram had been performed in 1969. (Figure 1) At that time a small collection of barium appeared posteriorly. Only one film is available but the finding is compatible with a small pharyngoesophageal diverticulum. This study of the esophagus demonstrates an abnormal collection of barium with an air fluid level.

An oblique projection shows the diverticulum somewhat better. (Figure 2) This is classified as a pulsion diverticulum. This is in contrast to the traction type of diverticula which arise in the

mid-esophagus and often from adjacent lymph node attachments.

**Dr. Casey:** Preoperatively, the patient received a clear liquid diet for 24 hours. Antibiotics were started and continued into the postoperative period. The approach in this patient was through a left transverse cervical incision. The sternocleidomastoid was retracted laterally and the fascial attachments along the anterior border were divided. The omohyoid muscle was divided between clamps. The cervical fascia investing the omohyoid and strap muscles was divided and the left thyroid lobe was retracted medially. The diverticulum was visualized and dissected free by blunt and sharp techniques. A bougie was passed into the lumen of the esophagus to define the wall of the esophagus and the neck of the diverticulum. Stay sutures were placed on either side of the diverticulum and the mucosa was closed with absorbable sutures as the diverticulum was excised. A second layer of interrupted fine silk sutures was placed to complete the closure.

### HISTORY

The historical background of the diagnosis and treatment of pharyngoesophageal diverticulum is interesting. In 1764, at the Mitre Tavern in London, there was a meeting of the Society of Physicians, which subsequently evolved into the London Medical Society. At the meeting Dr. William Hunter read a communication from Abraham Ludlow entitled, "A Case of Obstructive Deglutition from a Preternatural Dilatation of and Bag Formed in the Pharynx." This article was later published in the Society's "Medical Ob-



**Figure 1**  
Zenker's diverticulum was demonstrated in 1969.

servations and Inquiries" in 1767.

In 1875 Zenker and Zeemssen collected 22 cases from the literature and presented five cases of their own. They were the first to classify diverticula of the esophagus into the traction and pulsion types.

Esophageal diverticula are characterized according to 1) location 2) mode of development and 3) whether they are true or false diverticula. In terms of location, there are the pharyngo-esophageal, midthoracic, and epiphrenic diverticula.

The midthoracic diverticulum is almost always secondary to an inflammatory process in the mediastinum with subsequent distortion of the esophageal wall as scarring occurs. Therefore, it is called a traction diverticulum. It is a true diverticulum because it contains all the layers of the esophagus.

The pharyngoesophageal and epiphrenic diverticula are believed to be secondary to esophageal motility disorders. Normal swallowing requires a coordinated sequence of muscular relaxation and contraction to create an effective peristalsis. This is not the case with patients having Zenker's or epiphrenic diverticula. Failure of the cricopharyngeus and the lower esophageal musculature to relax during deglutition is believed to produce high intraluminal pressure and cause



**Figure 2**  
Marked increase in size of Zenker's diverticulum was found by barium swallow 12 years later.

the mucosa and submucosa to bulge out through weak areas in the muscular layer to form false diverticula. Thus Zenker's diverticulum is an acquired abnormality that usually occurs in elderly persons. Once a pharyngoesophageal diverticulum forms, progressive enlargement occurs as demonstrated by the present case.

The late Dr. Frank Lahey described three phases of development of Zenker's diverticulum which correlates anatomy and clinical symptomatology. In the first phase, a true sac does not exist, but a bulge in the mucosa and submucosa protrudes through the posterior pharyngeal dimple. The symptoms which occur at this phase are minimal.

In the second stage the sac becomes more globular in shape. Although some food may enter the diverticulum, there will still be a direct pathway into the esophagus into which most of the food bolus will pass *en route* to the stomach. The symptoms related to this stage are those that result from the accumulation of food, fluid and mucus



within the sac, but significant complaints are absent.

Regurgitation may occur at an unpredictable time: during swallowing of a subsequent meal, between meals, by turning the head from one side to the other, or in the middle of the night, as our patient feared. Often these patients are awakened suddenly as they aspirate.

The third stage of development involves obstruction. The mechanism of esophageal obstruction is based on the fact that the large, food-filled diverticulum extends farther and farther down, and can actually reach the mediastinum. This converts the diverticular opening from a laterally placed slit into a widely patent transverse one. Food has a direct route into the diverticulum. Correspondingly, the lumen of the esophagus is displaced laterally, thus making the passage of food into the esophagus essentially an overflow phenomenon.

At this point, all the symptoms mentioned in the second phase apply, but because of the increased difficulty in swallowing due to the obstruction, patients taper their diets and subsequently develop nutritional deficits.

The diagnosis of Zenker's diverticulum is generally made directly by the history. Barium swallow confirms the diagnosis. Endoscopy is seldom necessary, may even be hazardous in inexperienced hands and should not be performed unless a barium swallow has been performed.

The typical symptoms are difficulty initiating swallowing, early regurgitation of swallowed food unchanged by digestion, gurgling noises described during eating, and regurgitation of food and saliva when the patient tips forward or lies down, particularly in bed at night. The treatment for this problem is surgical.

#### FIRST RECORDED SURGICAL REPAIR

The first surgical repair of a Zenker's diverticulum was in 1877 when Nicoladani, using an idea from Bell, created a fistula from the diverticular pouch to the skin in the 1830's.

The first excision of a diverticular sac was in 1884 by Niehaus, who excised the sac two weeks after he had removed a goiter. In 1896, invagination of the sac was performed by Girard with suture of the esophageal wall. This fell into disfavor when instances of patients aspirating their sacs were reported.

Until the turn of the century, the use of the one-stage procedure with excision of the sac was the vogue. This was associated with a high mortality rate, often greater than 10%, due to the leakage of the suture line or the ligated sac. This leakage produced mediastinitis, as the cervical

planes in this region are continuous with those of the mediastinum. Such infections were usually fatal.

In 1909, E.E. Golman introduced the two-stage procedure, freeing the pouch and ligating the pedicle with silk. Then he fixed the sac to the surface of the wound. The second stage was performed two weeks later by resecting the sac within the granulating wound.

Several modifications of the two-stage procedure ensued, including those by John B. Murphy in 1916, and Frank Lahey in 1923. This was considered a safer procedure and reduced the mortality from over 10% to less than 4%.

With the availability of effective antibiotics and improved surgical techniques, the mortality and morbidity for a one-stage operation declined to a level less than that of the two-stage procedure during the 1940's and 50's. At the present time this is the preferred surgical procedure.

**Dr. John Beal:** This patient is interesting because he had X-ray documentation of progression in his Zenker's diverticulum over a twelve year period. Recently there has been discussion concerning the relative merits of diverticulectomy and cricopharyngeal myotomy. In this patient, diverticulectomy was selected because the diverticulum was quite large. Excision is preferable for large diverticula and was accomplished without complication in this patient. He has been swallowing normally since surgery.

Ellis has reported uniformly good results with cricopharyngeal myotomy and has documented improvement in deglutition with manometric technics. Patients with bulbar palsy did not improve but others responded well. The improvement that occurs after myotomy supports the concept that Zenker's diverticula are caused by abnormal function of cricopharyngeal musculature. Myotomy appears to be well suited to diverticula that are four centimeters or less in diameter. ◀

#### References

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3. Welsh, C.F. and Payne, W.S.: "The Present Status of One Stage Pharyngoesophageal Diverticulectomy," *Surg Clinics of North America* 53 (4):953-958, August, 1973.
4. White, I.L.: "Severe Complication of a Zenker's Diverticulum with Endoscopic Diverticulotomy Rescue," *The Laryngoscope* 91:708-719, 1981.
5. Ravitch, M.M.: *A Century of Surgery*, Lippincott, Philadelphia, 1981, 884-886.
6. Spiro, H.: *Clinical Gastroenterology*, 2nd Ed., MacMillan, New York, 72, 1977.
7. Sabiston, D.C., Jr., (ed) *Textbook of Surgery*, 11th Ed., Saunders, Philadelphia, 893, 1977.

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## MISCELLANEOUS

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*For further information write or call:*

The Cook County Graduate School of Medicine  
707 South Wood Street  
Chicago, Illinois 60612  
(312) 733-2800

## EKG

*(Continued from page 247)*

**Answers: 1. C. E. 2. A.**

An accelerated idioventricular rhythm is a ventricular rhythm that occurs at a rate of 50 to 100 beats per minute, usually in short runs of three to thirty beats in a row. It usually occurs as an escape rhythm when the sinus rate slows down or AV block occurs. The incidence of accelerated idioventricular rhythm is approximately 10% in the setting of acute myocardial infarction, perhaps more often seen with acute inferior wall infarction. In the rhythm strips presented, it is seen in each panel, *e.g.*, beats 5 through 9 of the top strip, and the first five beats and beats 10 through 13 of the bottom strip. The slight changes in QRS shape of the ventricular beats are caused by ventricular fusion with the sinus beats. If the P-P cycle is measured with calipers, these P waves can be marched through the accelerated idioventricular rhythm. This is A-V dissociation. The first sinus beat following the accelerated idioventricular rhythm conducts with a long PR interval caused by retrograde concealed conduction. The rate of the ventricular rhythm is slightly faster than the sinus. The R-R cycle of the accelerated idioventricular rhythm is 720msec or 83 beats per minute and the sinus R-R cycle is 820msec or 75 beats per minute with some sinus arrhythmia. This rate is too slow for ventricular tachycardia. The incidence of hospital mortality and ventricular fibrillation is not increased in patients with accelerated idioventricular rhythm. If the patient remains asymptomatic, as ours did, it is likely that no treatment will be necessary. However, if angina, heart failure, marked bradycardia with hypotension occurred with this arrhythmia, then treatment would be needed. Atrial pacing or intravenous atropine have been used to override the ventricular rhythm. The danger of lidocaine, quinidine, procainamide, or direct current cardioversion is that suppression of the accelerated idioventricular rhythm will result in asystole. Therefore, a viable sinus rhythm is required before these approaches are used. Our patient had sinus rhythm present with AV dissociation during the bursts of accelerated idioventricular rhythm. For further reading on the subject of ventricular arrhythmias and ischemic heart disease, see Bigger, *et al*: *PROGRESS IN CARDIOVASCULAR DISEASES* 19:255, 1977. ◀



# Medicaid-Medicare-Champus Report

## IDPA Procedures for Drug Product Prior Approvals

**Inquiries Received:** ISMS has been receiving inquiries from physicians and their office personnel regarding the mechanisms for obtaining prior authorization to prescribe drug items not recommended for inclusion in the IDPA Drug Manual. The purpose of this article is to explain the prior approval procedure and to clarify the information physicians and their patients receive regarding this process.

States which administer a Medicaid program may provide coverage to recipients for services not mandated by Federal Medicaid regulation. An optional service that Illinois provides to its Public Aid recipients is coverage of drug and pharmaceutical products.

Before the process for obtaining a prior approval can be explained, it is necessary to understand the process by which drug products are approved for inclusion in the IDPA Drug Formulary.

The Illinois Department of Public Aid has contracted with a panel of pharmacologists who perform research and review of drug products proposed by the pharmaceutical manufacturers for inclusion in the IDPA Drug Formulary. Once the IDPA pharmacological panel has completed its review of a drug product proposed for inclusion, the pharmacologists present their findings to the ISMS Committee on Drugs and Therapeutics. This Committee then recommends those drug products it believes should be included in the Formulary for coverage by IDPA to the ISMS Board of Trustees. The Committee may also recommend that certain drug products be removed or not included in the Formulary. The purpose of developing a prior approval mechanism for approving drug products that are not in the Formulary is to give physicians who are treating a specific medical problem an opportunity to prescribe products not covered in the Formulary. These special cases occur when, in the physician's judgment, the products approved for reimbursement in the Formulary do not provide the desired results for a particular medical problem. The *Illinois Department of Public Aid* will review requests for prior approval of drug products on a case by case basis.

Prior to October 1981, requests for prior approval of drug products were directed to the ISMS Committee on Drugs and Therapeutics and subsequently forwarded to IDPA. However, on October 1, 1981 the Illinois Department of Public Aid assumed direct control for administering the prior approval of drug products. An individual request to prescribe drug items not covered in the IDPA Drug Formulary, for a specific condition, must be forwarded to IDPA.

All requests for prior approval of a drug product not listed in IDPA's Drug Formulary should be sent in writing to: IDPA Offices, 931 E. Washington, Springfield, Illinois 62762, Attn: Dawn Atkins-Gottrich. Requests may be made by physicians or office personnel who work under the physician's direct supervision. IDPA will also accept a request for prior approval from pharmacists, facility nurses and social workers who initiate such requests at the direction of practitioners who are licensed to prescribe under Illinois law.

Each prior approval should include the following information: the patient's name, address, individual Medicaid Identification Number (from the "green card"), the specific diagnosis, the drug name (including drug strength, quantity and dosage), length of time the prescription is to be taken, any proposed refill privileges and a listing of other drugs previously prescribed for the patient during the treatment of the medical condition.

In emergency situations a physician may obtain a prior approval for a drug product by calling the IDPA toll free number, 800-252-8937. Prior approvals obtained by telephone should always be confirmed in writing to the Department within 10 days.

The Department of Public Aid will consider granting prior approvals for drug products based on two major criteria: (1) that the drug requested will prevent the patient from being hospitalized and (2) that the drugs currently approved in the IDPA Drug Formulary for the diagnosed illness are not effective in the treatment of a patient's medical condition.

The major reason for IDPA to disapprove the use of drugs not listed in the Formulary is that the drugs requested may not be approved by FDA for the indicated diagnosis, or that IDPA's panel of pharmacologists believe that alternative drugs for effective treatment of a particular medical condition are currently included in the Formulary.

Physicians who treat and prescribe for certain types of medical conditions where all categories of effective drug products necessary to achieve a good result are not listed in the Formulary, may request a review of

those therapeutic drug classifications by the ISMS Committee on Drugs and Therapeutics.

While IDPA will review all prior approval of drug products on a case by case basis, the ISMS Committee on Drugs and Therapeutics will continue to respond to the needs of physicians who find that the successful treatment of some medical conditions are hampered by the limitation of approved drug products in the IDPA Formulary.

**Basic Health Protection Plan:** In an effort to contain costs in the coming fiscal year, IDPA has developed a Basic Health Protection Plan for Public Aid recipients in categories GA, AMI and AFDC MANG adult. This plan is designed to limit health care coverage primarily to those services which are mandated by Federal Medicaid regulations. The Basic Health Protection Plan provides coverage for those products which are considered necessary for life maintenance and to avoid life threatening emergencies. The Department will not provide reimbursement to physicians or pharmacies for drugs prescribed to IDPA recipients eligible under these categories that do not meet the life support criteria.

A complete listing of drug products that IDPA considers to be life supporting and covered for these categories of recipients (GA, AMI and AFDC MANG adults) has been outlined in the *Illinois Register* and the IDPA Drug Formulary.

The drug element of the Basic Health Protection Plan for GA, AMI and AFDC MANG Adults became effective August 1, 1982. ISMS informed the Department that the implementation of the provisions of this plan, including restrictions of drug products, may adversely effect the treatment of GA, AMI, AFDC MANG adult patients who were receiving certain therapeutic drug products for life threatening situations. Therefore, the Department will continue coverage of those drug products prescribed for life threatening conditions to patients in these recipient categories. In other words, those recipients receiving drug products for life maintenance situations prior to the implementation of the drug element of the Basic Health Protection Plan may continue to receive treatment with those drug products until November 15, 1982.

After November 15, 1982, physicians who wish to provide treatment using drug products necessary for life maintenance or to avoid life threatening emergencies can obtain *special* authorization from IDPA by calling 800-252-8937.

Physicians should be aware that the ISMS Committee on Drugs and Therapeutics will continue to review and recommend those drug products which are considered to be therapeutically effective and necessary for inclusion in the IDPA Drug Formulary.

**Timely Submittal Rule:** Earlier this year, ISMS encouraged IDPA to suspend its timely submittal rule in order to avoid penalizing physicians whose claims were part of the significant claim processing backlog experienced by IDPA during the initial stages of MMIS implementation.

However, IDPA has reinstituted its six month timely submittal rule for all physician MMIS claims with dates of service subsequent to July 1, 1982.

IDPA *will not* accept for claim processing those MMIS claims received beyond the timely submittal limit. Exceptions to the timely submittal rule may be allowed in three circumstances. First, the patient is in the process of applying for eligibility under the Medical Assistance Program and the patient's application has not been approved by IDPA on the date that service was rendered. In those instances where the Department is slow to process a recipient's application for eligibility the physician's claim for service can be submitted to IDPA within the six months following IDPA's approval of the application. The physician should append a copy of the patient's IDPA "green card" or Certificate of Eligibility to the claim form.

A second exception to the timely submittal rule is allowed if a patient does not inform the physician that he/she is an eligible recipient for benefits under IDPA's Medical Assistance Program. In these situations the physician may submit claims to IDPA beyond the six month time period. However, the physician should append a copy of any correspondence between the physician and the patient, another third party carrier, or a collection agency indicating that an effort to obtain a settlement of the claim had occurred. IDPA will also accept a dated copy of the physician's billing statement that indicates an attempt was made to bill the patient as a private paying patient.

The last exception to IDPA's six month rule involves untimely adjudication of the claim by a third party payor. If a third party carrier fails to adjudicate a physician's claim within the prescribed time frame, the physician may submit the claim to IDPA and append to the MMIS claim a copy of the explanation of medical benefits within six months of the final adjudication date by the third party carrier.

Many physicians are experiencing MMIS claim suspension for a variety of pricing and eligibility reviews. Physicians should retain a copy of the original Remittance Advice Sheet indicating the date of the claim suspension in order to verify compliance with the timely submittal rule.



Physicians who have submitted MMIS claims to IDPA and have not received information regarding the status of their claims may resubmit a second claim form duplicating the information reported on the first claim to the Department for processing.

*Physicians should allow IDPA between 45 and 60 days to process and report the status of MMIS claims prior to resubmitting a second MMIS claim.* Physicians should only resubmit those MMIS claims that have previously been rejected for claim form completion errors. *All corrected claims must be resubmitted on a new MMIS claim form.* Those MMIS claims that have not been fully adjudicated because of payment reduction, claim suspension or rejection may be resubmitted to IDPA within 12 months of the original date of service. Physicians should not, however, resubmit MMIS claims that are suspended pending a pricing or eligibility review by the Department. Once the review is completed, the status of the claim will be reported by IDPA on a subsequent Remittance Advice Sheet.

**Medicare:** EDS-Federal has available for distribution a revised Procedure Code Manual. This Manual will be sent to physicians *only* by written request. Physicians or their office staff who desire to obtain a Revised EDS-F Procedure Code Book should forward written requests to:

EDS-Federal Corporation, Professional Relations Department  
999 East Touhy Avenue, Suite 800  
Des Plaines, Illinois 60018  
Attn: Procedure book request

Physicians should include their complete name, address, phone number and medical specialty on all requests for this manual. There is no charge for ordering this procedure code book from EDS.

ISMS is committed to pursue the adoption of the CPT-IV procedure coding system by all third party payors. CPT-IV is the only procedure code system endorsed by ISMS. EDS-Federal has sought permission to use CPT-IV. However, their request was not approved by the Health Care Finance Administration (HCFA).

If you have further inquiries on governmental and private third party payors, please do not hesitate to contact your ISMS Field Representative at (312) 782-1654. Chicago area physicians may contact Christine Szuflita of the Chicago Medical Society at (312) 670-2550.

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# REPORT

## FOR *Illinois Physicians*

### SYMPOSIUM VII SCHEDULED NOVEMBER 18

An all-star line-up of speakers has been assembled for Blue Cross and Blue Shield of Illinois' 7th annual Health Care Symposium to be held on Thursday, November 18, at the Hyatt Regency Chicago Hotel. The theme for this year's Symposium is "The Health Care System: Forces for Change."

Among those addressing the gathering will be the Secretary of Health and Human Services Richard Schweiker; Former Vice President of the United States Walter "Fritz" Mondale; Arnold Relman, M.D., editor of the prestigious *New England Journal of Medicine*; Alan Greenspan, leading economic advisor to the Reagan

run until approximately 4 p.m. The registration fee is \$60 which includes lunch. Reservations should be made as soon as possible because seating is limited. Checks should be made payable to "Health Care Service Corporation" and mailed to Public Affairs, Blue Cross and Blue Shield of Illinois, 233 North Michigan Avenue, Chicago, Illinois 60611. For Further Information contact Laura Boyd (312) 938-6160 or Gus Rose, (312) 938-6155.



Arnold Relman, M.D.  
Editor  
The New England Journal  
of Medicine

Administration and Herman Kahn, America's foremost futurist and author of "*The Next 200 Years*."

Also on the program are Richard H. Egdahl, M.D., vice president of Health Affairs at Boston University; Eli Ginsberg, director of Conservation of Human Resources at Columbia University and Bernard Tresnowski, president of Blue Cross and Blue Shield Associations. There will also be a panel on the subject: "Health Coalitions—Defining the Consumer's State in Health Care." This panel will explore the current and future impact of the coalition philosophy from several perspectives.

The Symposium is scheduled to begin at 8:30 a.m. and



Alan Greenspan  
Leading Economic Advisor  
The Reagan  
Administration



Walter "Fritz" Mondale  
Former Vice President  
of the United States



# Cost Containment Program Saving Millions

Nearly \$4 million in health care costs were saved over the past two years through a program established by Blue Cross and Blue Shield of Illinois aimed at reducing the length of inpatient hospital stays.

C. Jonathan Shattuck, Vice President of Hospital Affairs for the Illinois Plan, said "our Guaranteed Payment/Hold Harmless Program achieved these results despite the fact only 13 of the 21 hospitals currently participating have been in the program long enough to provide meaningful data.

"According to our studies, the Guaranteed Payment/Hold Harmless Program produced \$1.2 million in savings for Blue Cross and Blue Shield members during its first full year of operation (1979-1980) and \$2.5 million the second year (1980-1981)," Shattuck said. "We are confident that savings will be even greater when those hospitals already in the program add to their experience and more hospitals are added to the program.

"The 21 hospitals now participating provide services to approximately 23.8 percent of the Illinois Blue Cross members hospitalized during the year," Shattuck explained. "Plans call for the addition of 24 hospitals during 1982."

The program operates through an agreement between

our Blue Cross Plan and a hospital," Shattuck said. "We agree to pay for all covered services during a three-month period. At the end of the period, we determine what percentage of the services would have been disallowed under normal review by our Plan's claims processors.

"If we find the disallowance figure is less than one percent, we will continue paying for all covered services during the next three-month period," Shattuck continued. "However, if the disallowance (denial) figure is above one percent, we will pay only allowable services and the patient is 'held harmless' by the hospital for any additional costs. This takes the member out of the middle in any discussions between Blue Cross and the hospital over the appropriateness of hospital services."

## All Claims Reviewed

"Our normal practice is to review every hospital claim filed with the Plan for appropriateness of service and make payments accordingly," he pointed out. "If through this process all or a portion of the hospital bill is disallowed, the hospital can bill the patient for the disallowed services.

"One incentive on the part of the hospital to participate in the Guaranteed Payment/Hold Harmless Program is the elimination of the need to bill patients for disallowed charges and thus avoid the subsequent risk of bad debts. It also allows a hospital to publicly demonstrate that it does support programs which improve services for its patients while holding costs down," Shattuck said.

"Interestingly enough, savings are not based solely on a reduction in hospital stays," he pointed out. "During our review of the program, we found two hospitals in Downstate Illinois reporting increases in length of stays for Blue Cross surgical patients. Through further examination, we found that both hospitals had launched new ambulatory surgical programs, which meant that short inpatient stays were being shifted to the outpatient setting and only the more serious, longer stay cases, were being handled on an inpatient basis.

"In short, while the length of stays of Blue Cross surgical patients increased at these two hospitals, there were fewer inpatient admissions which resulted in an overall savings," Shattuck said.

## AMA Management Workshop

Management techniques for more efficient medical business practices will be the subject of a workshop, "Medical Collection Management," to be presented by the American Medical Association (AMA) in Chicago, November 10, and December 8, and in Oak Brook, November 11.

The half-day workshop demonstrates proven techniques for incorporating efficient, ethical business practices into everyday office procedures. Course content focuses on development of a comprehensive system of collection policies and procedures which can yield measurable results for your medical office.

The workshop will be offered twice each day so that persons planning to attend can select the time most convenient for their schedule. Registration for the morning sessions will begin at 8:00 a.m., and for the afternoon sessions at 12:30 P.M. The registration fee includes a workbook/reference manual.

To register for the workshop, or for more information, call (312) 751-6667 collect, or write the Department of Practice Management, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

## Correction

(PLEASE NOTE: an error was made in reporting the previous position of Ronald A. Ferguson, M.D., Blue Cross and Blue Shield of Illinois' new medical director. It should have read... Dr. Ferguson was vice president of the Department of Family Practice at Columbus-Cuneo-Cabrini Medical Center and Co-Director of the Section of Family Medicine at Northwestern University Medical School.)

## ***Simple, Time Proven Concepts***

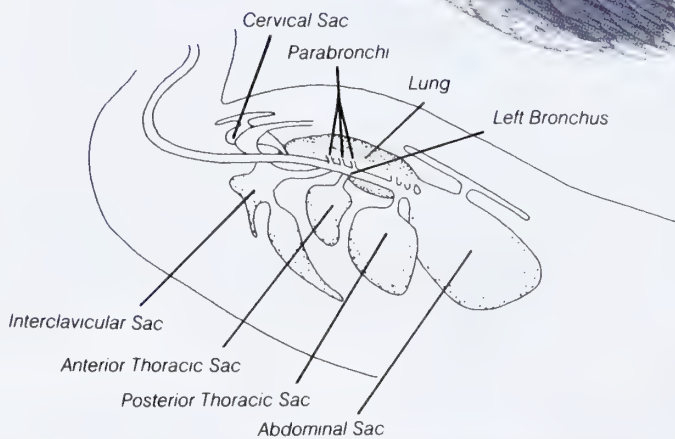
The case report entitled "Post-Cholecystectomy Retained Gallstone in an Abdominal Sinus Tract" again reminds us as physicians and surgeons of a need to appreciate the simple and time proven concepts regarding wound healing. If wounds or suture lines do not heal, or break down after apparent healing, one must consider the presence of an unusual septic process such as a fungal or tubercular organism, a retained foreign body—either related to the original problem or iatrogenic in nature, or the fact that there may be underlying tumor or obstructive lesions present. The present article by Dr. Davis again illustrates time proven surgical dicta, such as elimination of devitalized tissue, removal of foreign bodies and awareness of such as a potential source for a wound complication. This article further demonstrates that mere removal of one potential source of persistent inflammatory changes and infection, namely the wire sutures, does not necessarily eliminate the problem. In fact, they demonstrated with recurrent drainage, exploration of the wound is frequently necessary and may demonstrate a second source for the potential complication and a recurrent draining wound. Retained foreign bodies are not uncommon in the etiology of continued drainage from a wound. Persistent gallstones in a wound or incision are rather uncommon. Illustrated is the fact that if one course of treatment is not curative, additional modalities, including exploration of the wound, are necessary to eliminate potential continuing and as yet undiagnosed wound problems.

Raymond A. Dieter, Jr. M.D.  
Member, *IMJ* Editorial Board



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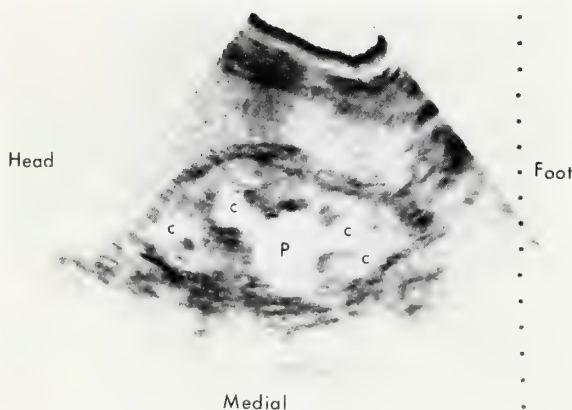


# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This month's Viewbox was prepared by Michael Flisak, M.D., department of radiology, Loyola University Medical Center, Maywood.*

*A 65 year old white female with chronic renal failure presented with a fever, elevated white blood cell count, right flank pain, and acute elevation of BUN and creatinine. Ultrasonography of the right kidney is shown. On retrograde pyelography the level of obstruction was the right upper ureter. A stent could not be advanced above the point of obstruction.*



**What procedure would be indicated next?**

- (a) Right nephrectomy
- (b) Surgical nephrostomy
- (c) Exploration of retroperitoneum
- (d) Percutaneous nephrostomy

**Figure 1**  
**Sonographic coronal section of right kidney. Dilated calices (C) and renal pelvis (P).**

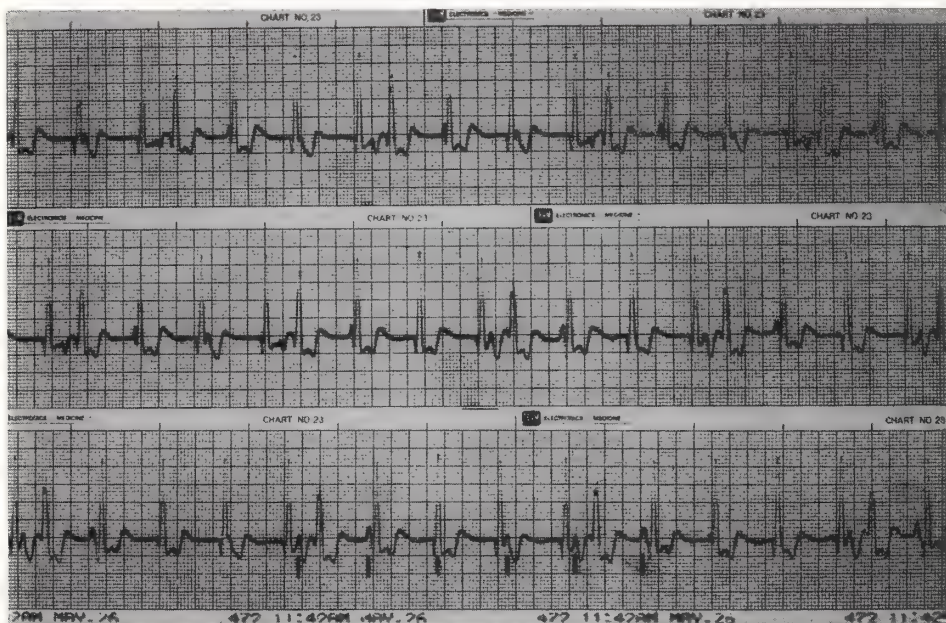
*(Continued on page 448)*



# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a 74 year old man who presented with severe chest pains. The pains were located in the retrosternal area of the chest and radiated to his neck. The pain had been occurring with increasing frequency and severity. The patient was aware of the seriousness of this pain because the same sort of pain had occurred with each of his two previous myocardial infarctions. Past history was important for a three year history of hypertension, one episode of congestive heart failure, as well as the two documented myocardial infarctions. He was hospitalized and his angina was stabilized. Coronary angiography demonstrated a 90% obstruction in the proximal left anterior descending and a 90% obstruction in large circumflex-obtuse marginal coronary arteries. The left ventricular angiogram suggested ventricular dysfunction involving the anterior wall, apex, and inferior wall of the left ventricle. A double aorta-coronary saphenous vein bypass heart surgery was performed. Postoperatively, he had a low cardiac output syndrome which was managed with dobutamine intravenously and the intra-aortic balloon pump. His digoxin dosage was increased. On the third postoperative day, this continuous ECG rhythm strip was recorded in the surgical intensive care unit.*



## Questions:

1. The ECG rhythm strip shows:

- Sinus rhythm.
- Frequent premature ventricular beats.
- Incomplete atrioventricular (AV) dissociation.
- An accelerated AV junctional rhythm.
- Ventricular tachycardia.

2. The management of this cardiac arrhythmia could include:

- Intravenous lidocaine bolus and then drip.
- Oral quinidine or procainamide.
- A temporary transvenous pacemaker.
- Discontinue digoxin.
- All of the above.

(Continued on page 426)

# ***Nominations and Supportive Information Due By November 30***

## **ISMS Team Physician Award**



(L-R): Clarence Fossier, M.D., team physician, Chicago Bears, Virgil Livers, former Bear defensive back now playing for the Green Bay Packers and Fred Caito, head trainer, Chicago Bears. (Photo Courtesy of Chicago Bear Report.)

The Illinois State Medical Society is now accepting nominations for the Team Physician Award. The award is an annual program designed to recognize physicians willing to contribute their skills to young athletes in Illinois and encourage other physicians to become team physicians.

Award presentations will include recognition of team physicians at a major Illinois athletic event. Physicians will also be recognized before their professional peers at the annual meeting of the Illinois State Medical Society. Up to five physicians will be honored each year with a distinctive plaque commemorating their service to athletic teams. Articles about selected team physicians will appear in local newspapers and the *Illinois Medical Journal*.

### **Eligibility**

Team physicians nominated must meet the following eligibility criteria:

- Maintain a license to practice medicine in all of its branches;
- Have tenure as a team physician at the high school or college level for a minimum of 10 years in a voluntary or paid capacity. (The physician need not have worked with

the same team, or for consecutive years); and

- Maintain a current membership in the Illinois State Medical Society. Retired physicians are eligible for the award.

### **How To Nominate**

Anyone may nominate a team physician for the award. Coaches, schools, athletes, parents, civic organizations and other physicians may choose to do so.

Persons seeking to nominate a team physician should contact the ISMS Division of Medical Services (312-782-1654) and request an application. They will be asked to complete and return the application with information regarding schools and sports, other community activities, educational programs conducted and evidence of the physician's dedication to athletics and the community.

Once the ISMS Sports Medicine Committee receives an application, the team physician is considered a nominee. The Committee will contact the school and the physician's county medical society to assist in the selection process. All nominators will be notified of the selected physicians.



# ***HYPERTENSION:***



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BEFORE USING Inderal (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

### CONTRAINDICATIONS

1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

### WARNINGS

**CARDIAC FAILURE:** In congestive heart failure, inhibition by beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when Inderal is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levaterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA:** Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

**USE IN PREGNANCY.** Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

### PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

### ADVERSE REACTIONS

**Cardiovascular:** bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. **Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory:** bronchospasm. **Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings.** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

### HOW SUPPLIED

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—Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).

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—Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains 80 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

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**Reference:** 1. Freis, E. D. Hypertension (Suppl. II) 3:230 (Nov.-Dec.) 1981.

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# Abstracts of Action

September 11, 1982

Arlington Park Hilton  
Arlington Heights, Illinois

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.*

## **DNR ORDERS**

Over a period of time the Board has been apprised of changing law and physician responsibilities regarding "do not resuscitate" orders. Acting upon a review of the matter, the Board adopted a report of the Medical-Legal Council and directed that guidelines for writing DNR orders be disseminated to all Illinois hospital medical staffs and be published in *IMJ*.

## **PHYSICIAN DISTRIBUTION IN ILLINOIS**

Earlier this year, the Board reviewed activities of the Illinois Board of Higher Education (IBHE), which was studying the matter of physician education, distribution and retention in Illinois. Purpose of the study was to identify recommendations for enhancing Illinois medical education programs and for means to improve retention in Illinois of graduates from Illinois medical schools. The study had been underway for over a year and various items had previously been commented upon by ISMS. Acting upon a review of the final report by the Council on Education and Manpower, the Board approved comment to the IBHE, endorsing the report with some qualifications.

## **FOREIGN MEDICAL GRADUATES**

Rule 1 for the Medical Practice Act, enacted by the Department of Registration and Education Medical Examining Committee, requires various documentation regarding programs at foreign medical schools as a condition for Illinois licensure and temporary certificates of registration. Various modifications to the current Rule have been proposed to expedite the process and relieve cumbersome review. The Board directed a six-point comment to the Committee to assist in clarifying and correcting the proposed revisions. The revisions will essentially "grandfather" all medical schools from which a graduate was licensed in Illinois prior to 1975. In addition, all foreign medical schools would be reviewed on a ten year cycle to assure that graduates receive consistently high quality education comparable to that received at U.S. schools.

## **INDEMNIFICATION**

An amendment to Illinois law was enacted in the current General Assembly to provide representation and indemnification to persons voluntarily providing advice and consultation to state agencies. Legal counsel reported on the context of the legislation. Based upon this, the Board directed that an outline of the recent changes be developed for distribution and be communicated to ISMS members.

## **FINANCIAL MATTERS**

The Board approved the June 30 financial statement and accepted reports on IMPAC and membership dues receipts.

In a continuing review of program activity and in keeping with a zero-based budgeting process, certain 1982 activities and projects were curtailed.

*(Continued on page 438)*



# Pulse of the ISMS Auxiliary

*Are You Aware . . .*

## Leadership In Illinois

BY MRS. DON HINDERLITER/ISMSA PRESIDENT

There are many definitions of what a leader is or ought to be. Some would say that a leader is a decision-maker, one who can delegate, an organizer, a thinker, a doer, one who can motivate. There is no such thing as a "born leader." Leadership is learned and it is composed of skill, training, and experience. No one style of leadership is always right. Individuals need to learn to evaluate what works for them and is most successful.

Leadership workshops and seminars enable auxiliarians to develop a potential leadership style. Developing future leaders for auxiliary is vital to the organization's continued growth. This development cannot be on a hit or miss basis where those who happen to be available are given the job. Successful leadership development takes planning.

This year four leadership workshops were held in Illinois, to enable every county to send potential leaders to a convenient location for training conducted by state officers and chairmen.

Among the topics covered were the fetal alcohol syndrome, membership recruitment and retention, the role of the district councilors, legislation and public affairs, and how auxiliarians can work effectively in the legislative arena, exercise for the aging, Medicare, and requirements for the election of the nominating committee and delegates to the national convention.

On October 10-12, 1982, the AMA Confluence was held at the Drake Hotel, Chicago. This is a national-level leadership development program instituted to aid states in developing their county leadership. Although this meeting is strictly for state presidents, presidents-elect, and county presidents-elect, state membership chairmen were

included also, for the first time this year. Topics covered were time management, parliamentary procedure, drug abuse, legislation, aging, parenting, working with the medical society and other organizations, and the midlife crisis facing Physician families.

Following the AMAA Confluence, Fall Conference was held in Bloomington, Illinois, to further aid the county leadership in implementing programs that work at the local level. Confluence participants shared with the state information they had gained. This sharing benefits more than just those who were able to attend. The programs at Fall Conference included DOC (Doctors Ought To Care) which covers smoking among teenagers, and how to avoid peer pressure to do something you don't really want to do, plus other topics pertinent to teenagers. A puppet show on stress in children was presented by the Peoria County Medical Auxiliary and covered some simple techniques to aid children in relaxation. Career consultants provided information on how auxiliarians could turn previous auxiliary talents into marketable skills. Other information was presented on teenage pregnancy, STD's, and how to work with local schools to educate our young on these problems.

This year's program was full with questions, answers, and round-table discussion. Auxiliarians are an excellent resource and a reservoir of information.

I am convinced as I have watched participants at county, state, and national levels that the leadership potential in Illinois is on sound footing, not just for the immediate future, but for many years to come. ◀



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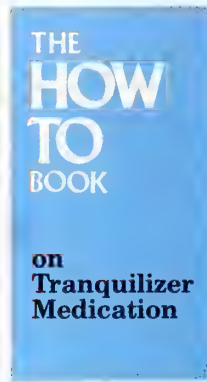
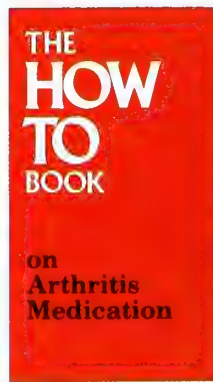
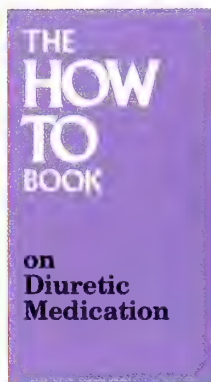
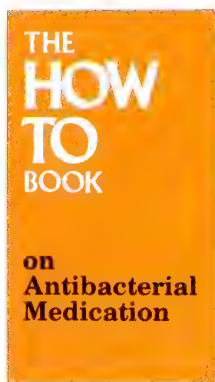
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\*Hannemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. C., Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. R.: Digital Plethysmography For Assessing Erythrityl Tetranitrate Bioavailability. Clin Pharmacol and Ther 29:35-39, 1981.

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**CONTRAINDICATIONS:** Idiosyncrasy to this drug.

**WARNING:** Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

**PRECAUTIONS:** Intraocular pressure is increased therefore caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.

**ADVERSE REACTIONS:** Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine and many other agents. An occasional individ-

ual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and / or exfoliative dermatitis may occasionally occur.

#### **DOSAGE AND ADMINISTRATION**

Oral / Sublingual Tablets: Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg. prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

#### **HOW SUPPLIED:**

**CARDILATE** (Erythrityl Tetranitrate) TABLETS (Scored)  
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# President's Page



## Dues

*Shortly, we shall all be receiving a statement of the 1983 dues for our county, state and national medical societies. To answer a question frequently asked by members, the staff of ISMS has prepared an analysis identifying the services and programs funded by dues income.*

### Membership Services Programs: 22%

- Dissemination of information pertaining to Medicare and Medicaid and intervention on behalf of individual practicing physicians with EDS Federal, Illinois Department of Public Aid, Blue Cross/Blue Shield and other insurance carriers.
- Presentation of statewide seminars informing physicians and their office staffs of how to handle insurance and other third party claims.
- Provision of life, health, disability and other insurance programs (with the exception of professional liability insurance which members may purchase from the Illinois State Medical Inter-Insurance Exchange).
- Funding of the impaired physician, physician recruitment and placement, and speakers' bureau programs.

- Administrative assistance to the specialty societies, the auxiliary and the fifty-year club.

Incidentally, the travel programs are not supported by dues dollars. In fact, they generate a small amount of revenue which accrues to the general funds of the Society.

### Representation and Advocacy: 16.6%

- Representation of the policies established by our House of Delegates before committees of the Illinois General Assembly involved in legislation affecting the health of the citizens of Illinois and our ability to deliver health care in the best and most cost-effective way.
- Representation of the private practicing physician before other federal, state and local regulatory agencies.

### **Communication with Members: 15.5%**

- Disseminating information of medical, socio-economic and political interest to physicians through *Illinois Medical Journal*, Action Report and Trustee District Reports.

### **Leading the Profession: 12.8%**

- Meetings of the House of Delegates, Board of Trustees, councils and committees.
- Visits by officers and trustees to county medical societies.
- Interviews with television and radio stations, newspapers and magazines throughout the state.

### **Education: 12.5%**

- Continuing Medical Education accreditation and seminars.
- Loss prevention program.

### **Building Medicine's Future: 10.3%**

- Medical student and resident sections.
- Medical school liaison.
- Student financial aid program.

### **Public Service: 6.9%**

- Peer review and utilization review activities.
- Programs on alcoholism and drug abuse.
- General health programs.
- Sports medicine.
- Public service announcements.

### **Membership Recruitment: 2.2%**

- Mailings and programs designed to reach and recruit new members.

This list is by no means all inclusive, but it does reflect the major activities of the Society. It would be unreasonable to expect all of us to benefit from all the services and programs offered by the Society at any one time, but most physicians will avail themselves of many of them at some time in their careers. It is important for us all to contribute to keeping these programs and services viable and worthwhile. ◀



Cyril C. Wiggishoff, M.D., President

## **Instructions for Authors**

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order*: Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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When thiazides are prescribed in doses greater than 50 mg/day, the potential for hypokalemia increases substantially. What's more, the greater the fall in serum K<sup>+</sup>, the greater the risk of hypokalemia-induced PVCs.<sup>3,4</sup>

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### BRIEF SUMMARY

(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

### INDERIDE®

BRAND OF  
propranolol hydrochloride  
(INDERAL®)  
and hydrochlorothiazide

No. 484—Each IINDERIDE®-40/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	40 mg
Hydrochlorothiazide	25 mg
No. 488—Each IINDERIDE®-80/25 tablet contains:	
Propranolol hydrochloride (INDERAL®)	80 mg
Hydrochlorothiazide	25 mg

**WARNING:** This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

**INDICATION:** IINDERIDE is indicated in the management of hypertension. (See boxed warning.)

**CONTRAINDICATIONS: Propranolol hydrochloride (INDERAL®):** Propranolol hydrochloride is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

**Hydrochlorothiazide:** Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

**WARNINGS: Propranolol hydrochloride (INDERAL®):** CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely; a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of prechordectomy, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA.** Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

**USE IN PREGNANCY: Propranolol hydrochloride (INDERAL®):** The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in

animal studies at doses about 10 times the maximum recommended human dose.

**Hydrochlorothiazide:** Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**Nursing Mothers:** Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

**PRECAUTIONS: Propranolol hydrochloride (INDERAL®):** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

**Hydrochlorothiazide:** Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

**ADVERSE REACTIONS: Propranolol hydrochloride (INDERAL®):** Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

**Central Nervous System:** lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

**Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

**Respiratory:** bronchospasm.

**Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

**Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**Hydrochlorothiazide:** **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

**Central Nervous System:** dizziness, vertigo, paresthesias, headache, xanthopsia.

**Hematologic:** leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

**Cardiovascular:** orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

**Hypersensitivity:** purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

**Other:** hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

**HOW SUPPLIED:** —Each hexagonal-shaped, off-white, scored IINDERIDE 40/25 tablet is embossed with an "I" and imprinted with "INDERIDE 40/25", contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 (NDC 0046-0484-81) and 1,000 (NDC 0046-0484-91). Also in unit dose package of 100 (NDC 0046-0484-99).

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# Obituaries

**\*Bell, Julius N.**, Chicago, died September 17, 1982 at the age of 65. Dr. Bell was a 1941 graduate of the University of Illinois College of Medicine.

**\*Blunck, Jay F.**, Winnetka, died September 18, 1982 at the age of 41. Dr. Blunck was a 1965 graduate of Northwestern University Medical School, Chicago.

**\*Bolino, Anthony**, La Grange, died September 20, 1982 at the age of 63. Dr. Bolino was a 1945 graduate of the University of Health Sciences, Chicago Medical School.

**\*Bonk, Alfred K.**, Skokie, died May 10, 1982 at the age of 82. Dr. Bonk was a 1925 graduate of the *Uniwersytet Jana Kazimierza Wydział Lekarski, Lwow*.

**\*\*Drenckhahn, Charles H.**, Champaign, died September 21, 1982 at the age of 78. Dr. Drenckhahn was a 1929 graduate of the Hahnemann Medical College and Hospital, Chicago.

**\*Hartung, Walter**, Bettendorf, Iowa, died September 27, 1982 at the age of 72. Dr. Hartung was a 1935 graduate of the University of Iowa College of Medicine, Iowa City.

**\*Jefferson, Nelson C.**, Chicago, died September 16, 1982 at the age of 70. Dr. Jefferson was a 1944 graduate of Meharry Medical College School of Medicine, Nashville, Tennessee.

**\*\*Koneski, Chester F.**, Bridgeport, died October 4, 1982 at the age of 78. Dr. Koneski was a 1930 graduate of Loyola University Stritch School of Medicine, Maywood.

**Lind, Carl M.**, Ashland, died September 4, 1982 at the age of 88. Dr. Lind was a graduate of the University of Health Sciences, Chicago Medical School.

**\*\*Mussil, Julius J.**, Skokie, died September 11, 1982 at the age of 86. Dr. Mussil was a 1925 graduate of Rush Medical College, Chicago.

**Reynolds, Samuel R. M.**, Doylestown, Pennsylvania, died September 25, 1982 at the age of 78.

**\*\*Sederlin, Elvin L.**, Los Angeles, California, died May 21, 1982 at the age of 89. Dr. Sederlin was a 1919 graduate of the University of Nebraska College of Medicine, Omaha, Nebraska.

**\*\*Seelye, Walter B.**, Kirkland, Washington, died July 26, 1982 at the age of 81. Dr. Seelye was a 1926 graduate of the Harvard Medical School, Boston.

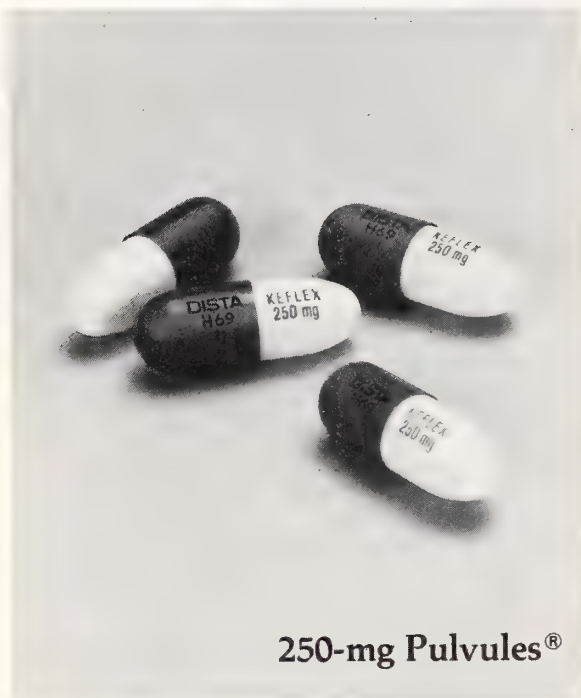
**\*Swearingen, Merle**, Lacon, died September 14, 1982 at the age of 51. Dr. Swearingen was a 1956 graduate of the University of Pittsburgh School of Medicine, Pittsburgh.

*\*Indicates ISMS member*

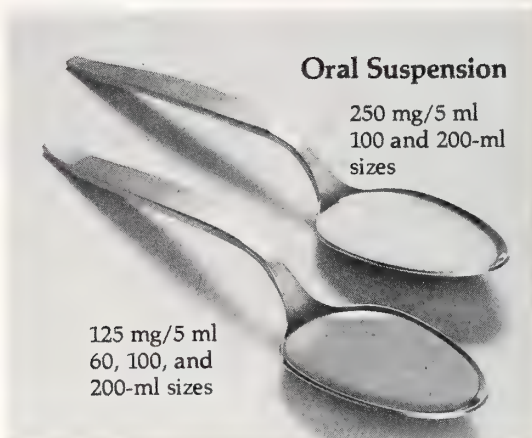
*\*\*Indicates member of the Fifty Year Club*



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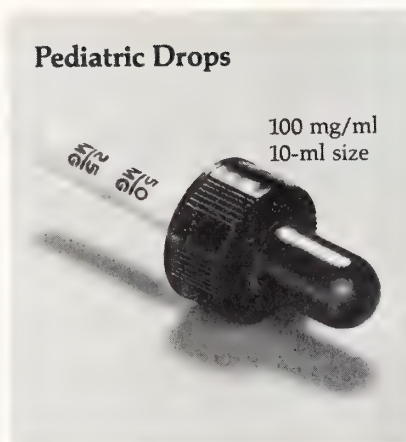
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**Mark Greenberg, M.D.**

Diplomate American Board of Radiology



# I M J

*Illinois Medical Journal*

Volume 162, No. 5, November 1982

## The Incidence Of Neonatal Circumcision In Illinois

BY EUGENE L. SLOTKOWSKI, M.D., AND LOWELL R. KING, M.D./CHICAGO

*In 1975, an American Academy of Pediatrics task force concluded that there are no valid medical indications for circumcision in the neonatal period. The United States is one of the few English speaking countries in which the neonatal circumcision rate has not dropped in recent years. In 1979, approximately 80% of male infants, both nationally and in the state of Illinois, were circumcised in the newborn period.*

Neonatal circumcision is the most frequent surgical procedure performed on males in the United States today. The incidence is estimated to be in excess of 80% of all male newborns. Approximately 1,500,000 newborn males were

circumcised in 1980.<sup>1</sup> These figures are based on projections of limited surveys rather than extensive data collection. Some hospitals do not code circumcision in the newborn period. Regional differences also exist, and the circumcision rate may vary from hospital to hospital within the same area. Marked errors in projection might result when only a limited number of hospitals are sampled.

National statistics that report newborn circumcision practices in the United States 30 years ago are a part of the Health Examination Survey conducted by the Department of Health, Education and Welfare (HEW) from July, 1963 to December, 1965.<sup>2</sup> It was based on physical examination of a statistically significant sample of 12-17 year old youngsters. Physical examinations were conducted for 3545 boys. One of the items noted was whether they were circumcised. Statistics from the survey should mainly reflect the neonatal circumcision practices in the early

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**EUGENE L. SLOTKOWSKI, M.D.**, is a board certified pediatrician affiliated with Children's Memorial Hospital in Chicago and a teaching associate at the Northwestern University Medical School.

**LOWELL R. KING, M.D.**, is a board certified urologist and head of the section of pediatric urology, department of surgery, Duke University Medical Center, North Carolina. Former chief of surgery at Children's Memorial Hospital, Dr. King has served as a professor of urology at the University of Illinois College of Medicine, and chairman of the department of urology at both Rush-Presbyterian-St. Luke's Hospital and Children's Memorial. At this writing, he was affiliated with Northwestern University Medical School in Chicago.



**Table 1**  
**National Circumcision Statistics: 1970-1980**

<u>Year</u>	<u>Male Births</u>	<u>Number Circumcised</u>	<u>Percent Circumcised</u>
1970	1,812,030	1,599,000	88
1971	1,744,200	1,536,000	88
1972	1,573,860	1,382,000	87
1973	1,526,430	1,355,000	88
1974	1,562,640	1,388,000	88
1975	1,575,390	1,383,000	87
1976	1,655,460	1,461,000	88
1977	1,747,770	1,520,000	86
1978	1,777,350	1,543,000	86
1979	1,767,660	1,494,000	84
1980	1,741,140	1,508,000	86

1950's, although some could have been circumcised after infancy. Of the total number of males in the Health Examination and Survey of 1963-1966, 76% were circumcised: whites, about 80% and blacks, about 45%.

National circumcision statistics for the years 1970-1980 are based on figures derived from the Hospital Record Study conducted by the Commission on Professional and Hospital Activities (CPHA) for member hospitals (Table 1). An average of 450-500 institutions provide their abstract records on a timely basis each quarter. Data is collected and projected as a national estimate.

In an effort to generate reliable data, a survey was undertaken to estimate the percentage of infants circumcised in the newborn period in the state of Illinois. We also hoped to determine if there had been any decline in the circumcision rate since the 1975 American Academy of Pediatrics task force finding of no valid medical indications for circumcision in the neonatal period.<sup>3</sup>

Letters were sent to 50 Chicago area hospitals; 18 provided neonatal circumcision statistics for one or more years. Fifteen additional hospitals responded but were unable or unwilling to participate in the survey. The incidence of neonatal circumcision for 1979 ranged from 27% to 93% with an average of 78% (Table 2).

A total of 143 Illinois hospitals outside the Chicago area were queried and 14 responded to the questionnaire. The incidence of circumcision ranged from 4.5% to 97%, with an average of 84.5% (Table 3). The circumcision rate for the state as a whole was 80%. The unusually low rate of 4.5% in one downstate hospital was confirmed by a second letter. They indicated without elab-

**Table 2**  
**Chicago Area Hospitals**  
**Circumcision Rate: 1979**

<u>Hospital</u>	<u>Male Newborns</u>	<u>Number Circumcised</u>	<u>Percent Circumcised</u>
1.	363	99	27
2.	491	218	44
3.	756	414	54
4.	209	119	57
5.	201	127	63
6.	355	237	66
7.	1363	923	67
8.	350	261	74
9.	609	491	80
10.	248	201	81
11.	1046	870	83
12.	794	699	88
13.	568	504	88
14.	1138	1032	90
15.	875	786	90
16.	807	738	91
17.	1420	1310	92
18.	384	347	92
	11,977	9376	78

oration that the circumcision rate began to decline after 1974-1975.

In general, the reason for fewer circumcisions in some hospitals is open to speculation. Variation probably reflects a mixture of parental expectations and their perceptions of standard care as well as the prevailing attitude of physicians at the particular hospital or area of the state. In general, the circumcision rate appears to be lower in Black and Hispanic segments of the population. Except for religious reasons, circumcision of the newborn male is an uncommon surgical procedure in European countries, Central and South America, and Asia. Recent immigrants, especially from Eastern Europe, tend not to want to circumcise the male infant born in the United States. The same is true of arrivals from Southeast Asia (Viet Nam, Cambodia, Korea, etc.). However, we have noted that the circumcision rate in male offspring of immigrants rises in proportion to the time the parents have been in this country.

Some hospitals provided circumcision statistics for as long as eight years. From these figures, it appears that the incidence of newborn circumcision has not changed significantly since 1975 in these specific hospitals, in spite of the failure of the Academy of Pediatrics to support neonatal circumcision. This has not been the case in other

**Table 3**  
**Downstate Illinois Hospitals**  
**Circumcision Rate: 1979**

Hospital	Male Newborns	Number Circumcised	Percent Circumcised
1.	270	12	4.5
2.	66	49	74
3.	91	89	74
4.	123	89	78
5.	341	286	83
6.	180	161	89
7.	465	413	89
8.	498	449	90
9.	218	199	91
10.	432	396	91
11.	267	249	93
12.	205	197	96
13.	139	136	97
14.	245	239	97
	4,038	3,413	84.5

countries with similar levels of medical sophistication.

A 1979 editorial in the *British Medical Journal*<sup>4</sup> comments on the falling circumcision rate in Britain. In the 1930's about one-third of British boys were circumcised. By 1949 the proportion had fallen to one-fifth. In hospitals in England and Wales in 1975 the rate was 6%.<sup>5</sup> Examination of Royal Air Force recruits born between 1930 and 1936 indicated an increasing frequency in the number circumcised as one ascends the scale of schools.<sup>6</sup> Circumcision is also more often performed among the affluent than among manual workers.<sup>7</sup>

The newborn circumcision rate in Australia for the year 1975 to 1976 was 43.7%.<sup>8</sup> The Australian Pediatric Association made the following recommendation: "... routine neonatal circumcision is founded partly on tradition and partly on a misunderstanding of a normal anatomy, that it is hardly ever necessary in infancy and seldom in later life, and that as neonatal circumcision incurs an appreciable morbidity and occasional mortality, its use as a routine measure cannot be justified."<sup>9</sup>

Statistics for Canada indicate a falling circumcision rate.<sup>2</sup> The figures are fairly definitive and are available from the Canadian National Health Insurance Program. In the four western provinces plus Ontario and Prince Edward Island, the rate is approximately 50%. In New Brunswick and Nova Scotia the rates are 40% and 22%. The

latest rate reported in Quebec is 13%.

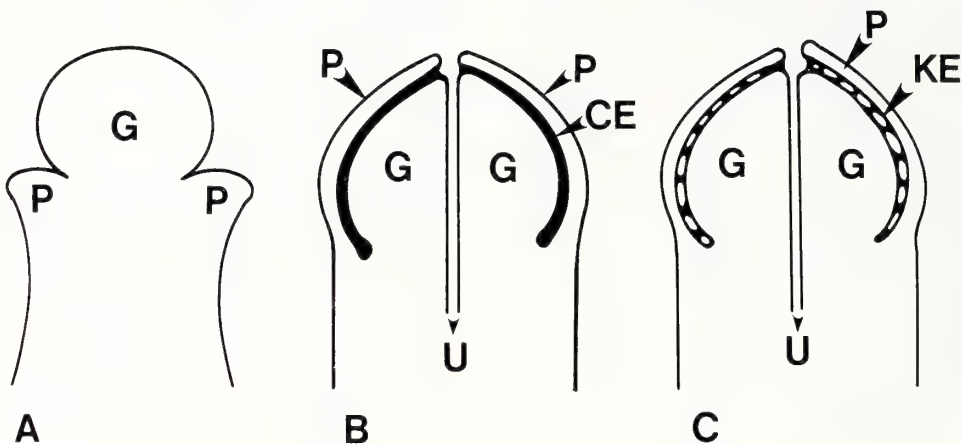
The rate of infant circumcision in New Zealand has decreased and is now about 25%.<sup>10</sup> In this study involving 590 infants, about two-thirds of the fathers had been circumcised, also indicating a dramatic reduction in the prevalence of the operation. The circumcision rate was higher in private (35.2%) than in public (19.4%) hospitals. Infants whose family doctors favored the operation had a higher incidence, as expected, but only a small minority of family doctors (7%) were reported to hold this view.

Contraindications to circumcision of the newborn include prematurity, neonatal illness, bleeding problems, congenital anomaly such as hypospadias, epispadias, ambiguous genitalia and meningo-myelocoele. Opponents of routine circumcision feel the infant is forced to submit to a painful mutilation which exposes him to potentially serious complications. They also claim that the operation in the newborn is based on custom, ritual and social pressure without any medical indications.

Those favoring circumcision of the newborn point out that carcinoma of the penis occurs less frequently in circumcised individuals. In India there is a higher incidence of penile carcinoma among Hindus (not circumcised) than among Moslems (circumcised). However, in Sweden, where circumcision is uncommon, the incidence of penile carcinoma is low. It has been suggested that good penile hygiene might afford as much protection as circumcision. Cook and Burkitt<sup>11</sup> found that the incidence of this disease was not necessarily related to circumcision. Some uncircumcised tribes in Africa with high standards of hygiene had less cancer of the penis than other tribes practising circumcision but with poor hygiene. In any event, the occurrence of carcinoma of the penis is uncommon in most Western countries.

Another argument in favor of newborn circumcision is the claim that a malignant neoplasm in the genital tract of women married to circumcised men is less frequent than in women married to uncircumcised men. Carcinoma of the cervix is less common in Jewish women than in Gentiles. This could have a genetic basis or might be related to the fact that nearly all Jewish boys are circumcised. The importance of circumcision of the male in the prevention of carcinoma of the cervix in the female is still in doubt however, since there are many variables and environmental differences between population groups. In one study<sup>12</sup> which excluded Jewish women, no association was found between cervical cancer and lack of cir-





**Figure 1**  
**Development Of Prepuce During Fetal Life**

**G Glans**

**P Prepuce**

**CE Common Epithelium**

**U Urethra**

**KE Keratinization of Epithelium**

- A.** At eight weeks of fetal life thickened epidermis starts to grow forward over the base of the glans penis.
- B.** By sixteen weeks the prepuce has grown forward to the tip of the glans and the two structures have a common epithelium.
- C.** By the sixth fetal month separation of the prepuce from the glans starts by keratinization of the common epithelial cells.

cumcision of the husband. In a 1965 study,<sup>13</sup> Aitken-Swan could not support the theory that women whose husbands are circumcised will be less likely to develop cervical cancer. Cancer of the cervix is relatively rare in Scandinavia, yet few males are circumcised there.

#### **Analysis of Factors**

Three factors may influence the future neonatal circumcision rate. First, a better understanding of the normal development of the prepuce. Second, realization that circumcision is not an innocuous procedure. Third, an obligation on the part of the physician to discuss with the parents

of the infant the pros and cons of this surgical procedure—in other words, informed consent.

During early embryonic life the glans penis is gradually enveloped by the growing prepuce (Figure 1). Fusion takes place between the inner epithelium of the prepuce and the glans penis, both of which are covered by stratified squamous epithelium. By the sixth month of fetal life there is evidence of beginning separation of the prepuce from the glans. The separation is the result of keratinization or desquamation of intervening epithelium. These areas or pockets of separation fuse with each other eventually, resulting in the separation of the epithelium of the glans from

the inner epithelium of the prepuce.

Separation of the prepuce from the glans is incomplete at birth. Separation continues during infancy and early childhood. The prepuce of the newborn can be completely retracted in only 4% of babies, but by 17 years of age the foreskin is completely retractable in 99% of males.<sup>14</sup>

Inability to retract the prepuce in the newborn is not an abnormal condition. It represents the still incomplete separation of the prepuce from the glans. Under the circumstances the term "phimosis" of the newborn is a misnomer and does not apply except to describe a normal physiologic state. In an uncircumcised infant the prepuce covers the glans during the years when the infant is incontinent, protecting the glans from irritation by the wet diaper.

Circumcision is frequently regarded as a minor surgical procedure. Weiss<sup>15</sup> revealed in his survey on ritual circumcision that "accidents" frequently occur in hands of *mohalin* (performers of ritual circumcision) but these are seldom reported in the medical literature or in Jewish sources. In addition to the obvious pain and stress, there is a risk of hemorrhage, infection or injury to the penis.<sup>16</sup>

Significant bleeding following neonatal circumcision varies from 0.1% to 35%. Most often it is minor and can be controlled by local pressure. Occasionally, sutures are required and, rarely, a transfusion.

### Associated Infections

Wound infection is the second most frequent complication. The exact incidence is not known but probably is more frequent than has been reported. The infection may be either limited to the circumcision area or extend to the remainder of the genitalia, perineum and abdominal wall. Fortunately most are minor in nature. Diffuse bronchopneumonia with multiple abscesses, staphylococcal septicemia resulting in osteomyelitis of the femur, diphtheritic infection of the circumcision wound, tetanus and partial necrosis of the penis secondary to infection, have been reported.

Immunologically the neonate is at a disadvantage. Neonatal neutrophils gave decreased capacity for locomotion and phagocytosis. There are defects in complement, opsonization and cell-mediated immunity.<sup>17</sup> These deficiencies increase the risk of infection in this age group.

The skin is a protective organ and any break in the integrity affords an opportunity for initiation of infection. The circumcision adds a wound which can be invaded by bacteria, some of which

have been altered by exposure to multiple antibiotics. There may be more deaths each year from complications of circumcision than from cancer of the penis.<sup>18</sup>

Surgical complications of neonatal circumcision may range from superficial laceration of the penis to necrosis of the entire organ necessitating reconstructive surgery, changing sex identity and raising the patient as a female.<sup>19</sup> Other complications include a denuded penile shaft from removing too much skin, urethral fistula, bridging of the skin between the penile shaft and the glans and partial circumcision when insufficient skin and preputial epithelium are removed.<sup>20</sup>

Bivalving either the dorsal or ventral half of the glans penis from inadvertent placement of one limb of the scissors into the urethra rather than between the foreskin and the glans has been reported.<sup>21</sup> A concealed penis is an unusual complication in which the penis is forced into the subcutaneous position by wound contraction following circumcision. A slipped plastic bell clamp may remain fixed on the glans and result in a permanent sulcus.<sup>22</sup> Urinary retention may occur as a result of a tight circular bandage used on circumcision.<sup>23</sup>

An unusual complication of circumcision may occur after treatment of local hemorrhage with topical epinephrine in high concentration.<sup>24</sup> Aqueous epinephrine (0.1 ml. of 1:1000 solution) was sprayed on the bleeding area. This was followed by local pallor of the penis and base of the shaft, probably due to vasoconstriction. Phenolamine solution was applied topically and given locally by injection. Eventually, all pallor disappeared. However, the authors suggest using a weak solution of epinephrine, 1:100,000 rather than 1:1000.

A consequence rather than complication of circumcision is the development of a meatal ulcer.<sup>14</sup> The reported incidence varies between 8%-31% of boys circumcised as newborns. Although limited primarily to infants and children who have been circumcised, it may be found in the non-circumcised if the prepuce leaves the tip of the glans free to irritation. Healing may result in scarring and meatal stenosis.

### Consent Issues

The customary surgical consent form alone cannot protect a physician from litigation if there are complications following circumcision. In order to meet the requirements of informed consent, the physician must relate to the parent or parents all material facts related to the proposed operation. The risks of morbidity and death should be



mentioned, as well as the alternatives to treatment—in this instance, noncircumcision.

The decision to circumcise is usually relegated to the mother who often probably decides on the basis of incomplete or erroneous information. Some mothers believe that circumcision is mandatory hospital policy or that circumcision is required by law. Apparently physicians commonly neglect to discuss the subject with the parents. According to Shaw and Robertson,<sup>25</sup> among 80 mothers of newborn male infants, 57 (72%) denied that a physician had ever discussed circumcision with them. Patel<sup>26</sup> reported parental discussion of circumcision with the doctor in only 34 of 100 cases.

Over the years, the circumcision rate has fallen in countries where it had been quite high. Will a similar change take place in this country? There are indications that patient education can result in a drastic drop in the circumcision rate. In 1978, at the Great Lakes Naval Hospital, 94% of male newborns were circumcised. When the physicians informed the mother of the various options and alternatives, the rate dropped to approximately

80%. For a three-month period parents also received a printed handout explaining the pros and cons of newborn circumcision and the rate dropped to 65%.<sup>27</sup> There is no real doubt that the physician's attitude can change the circumcision rate of the newborn. He or she need only agree with the 1975 recommendation of the American Academy of Pediatrics that circumcision confers no more health benefits than the simplest of hygienic measures. All that is needed is to teach the boy to wash the glans in the course of taking a bath or shower, after the foreskin becomes retractable. Since the boy is bathing anyway, this recommendation is really cost effective! Most importantly, considerable grief and morbidity in the treatment of complications are therefore almost totally avoided. ◀

## References

A complete list of references for "The Incidence of Neonatal Circumcision in Illinois," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago IL 60603.

# EKG

(Continued from page 400)

**Answers: 1. A, C, D  
2. D**

The ECG rhythm strip shows a junctional rhythm at a rate of 83 beats per minute. This is a tachycardia for normal junctional pacemakers, but it could be called an accelerated junctional rhythm because the rate is less than 100 beats per minute. There is sinus rhythm here at a rate of 75 beats per minute. The sinus P waves are marked by black vertical bars in the bottom strip. When the P wave occurs in early diastole, it captures the ventricles with a PR interval of 0.20 seconds. These beats occur early. Beats two, seven, twelve, and seventeen in the bottom strip are sinus capture beats. In the upper two strips,

a sinus capture occurs almost every fourth beat. These capture beats have a QRS that has a normal duration but slightly lower amplitude than the junctional beats. This suggests the junctional beats are being conducted with some degree of aberrant intraventricular conduction. AV dissociation occurs when the atria and ventricles are disconnected. If the atria occasionally sends an impulse to the ventricles, the AV dissociation is incomplete. In this case, the AV dissociation was caused by an acceleration of an ordinarily subsidiary pacemaker in the AV junction. The junctional pacemaker is slightly faster than the sinus mechanism. This is not AV block. The rate and QRS duration of the junctional beats make ventricular tachycardia unlikely. Commonly, an acceleration of the AV junctional pacemakers is caused by digitalis intoxication. Holding further digoxin therapy would be a first step while also evaluating serum electrolytes, arterial blood gases, and ischemia as other possibilities. ◀

# Special Articles

## Child Restraints

BY SANDRA B. BENCKENDORF, M.D., AND DAVID A. BENCKENDORF, J.D./PEORIA

*Editor's Note: The ISMS House of Delegates mandated in Resolution 29(A-82) and Substitute Resolution 18(I-81) that educational information regarding the benefits of seatbelt use and child safety restraints be provided to the membership. This article is intended to fulfill those actions.*

Between 1912 and 1979,<sup>1</sup> U.S. motor vehicle accident deaths shrank from 33 to three per 10,000 registered vehicles. Despite this, motor vehicle accidents are the leading cause of death and injury to children over one year of age.<sup>2</sup>

During an accident the safest place for a child is in a federally approved child restraint device or a standard car seat belt.<sup>3-5</sup> One study<sup>6</sup> showed

that of 26,550 unrestrained children involved in car accidents, 123 were killed and 678 sustained disabling injuries. Of 5,052 restrained children, only two were killed and thirty were disabled. This is a 70% reduction in injuries and more than a 90% reduction in deaths. Another study found that sixteen children were killed in auto accidents in Washington State in 1970; none were restrained.<sup>7</sup> Not one of 2,880 restrained children involved in auto crashes reviewed from 1970 through 1974 in Washington State was killed.<sup>7</sup>

One study<sup>8</sup> showed that 90% of passengers less than 10 years old ride unrestrained as do 89% of passengers over 10 years of age and 78% of drivers. Even if a child restraint device were obtained, 16% were not in use and 73% of those in use were not used correctly.<sup>8</sup> Child passengers were more likely to be restrained if the driver was restrained, but even then, more than 75% of the children were not.<sup>8</sup>

A mother's arms are *not* a safe place for a child riding in a car. In a 30 mile per hour collision, a seat-belted mother would need 600 pounds of force to prevent her newborn from impacting the dashboard.<sup>9,10</sup> The child's body often acts as a cushion between the adult and the dash during an accident when an unrestrained adult holds a child in her lap.<sup>11</sup> Over-the-seat infant carriers give no protection in a crash.<sup>5</sup> Unrestrained children in the front seat have the highest injury rate.<sup>12</sup>

**SANDRA BOWERS BENCKENDORF, M.D.**, is a second year resident at the UI College of Medicine at Peoria's Family Practice Residency Program, Methodist Medical Center of Illinois. A graduate of the UI Peoria School of Medicine, Dr. Benckendorf is an assistant professor of clinical medicine there, as well as a former member of the UI Women's Gymnastic Team.



**DAVID A. BENCKENDORF, J.D.**, is an attorney in private practice in Peoria, Illinois. Mr. Benckendorf is a graduate of the UI College of Law at Champaign.





## ISMS To Distribute Child Restraint Patient Brochures

Physicians seeking to obtain information for distribution to their patients on child seat belt safety may wish to contact the Illinois State Medical Society.

Beginning in November, ISMS will make available bulk quantities of "Don't Risk Your Child's Life," published by the Physicians for Automotive Safety.

That brochure provides straightforward and readily understood guidelines for parents seeking to protect their infants and children from automotive harm. It also includes motivating statistics on the risks of providing inadequate restraints. Tips on helping children to be comfortable within restraints are given, as well as a list of federally approved crash tested child seatbelt restraints.

All devices manufactured since the January 1, 1981, effective date of U.S. Department of Transportation standards for seat restraints must meet those standards. Information on earlier models may also be obtained by writing directly to the Physicians for Automotive Safety, PO Box 208, Rye, New York, 10580, or contacting the American Academy of Pediatrics First Ride Safe Ride program at 1801 Hinman Avenue, Evanston, IL 60204.

Physicians seeking to provide the safety brochures to patients may order them in lots of 100 directly from the ISMS division of medical services. Requests should include a check, payable to "ISMS-Car Seats," in the amount \$16.00 for each 100 brochures to cover direct costs, postage and handling. Brochures should arrive within 2-3 weeks.

Thirty-five percent of unrestrained children are ejected from motor vehicles, often landing head first on the street.<sup>13</sup> The idea that the safe driver needs no protection is false: the majority of multiple vehicle crashes involving children are initiated by vehicles other than those in which the children were killed.<sup>5</sup>

There have been many attempts to increase the public use of seat belts and child restraint devices

in motor vehicles. Tasteful television messages have failed.<sup>14</sup> Even when new mothers were given safety information and provided with a *free* car seat, only 40 percent of the seats were placed in the auto's passenger compartment at discharge from the hospital, and only 12% were used to transport the baby.<sup>15</sup> The arms of an adult were still the most common mode of car travel for these infants.<sup>15</sup> There was a 19% increase in infant carrier use among mothers given literature as opposed to those given none, but relatively no change in carrier use when a "health educator" discussed safety with them. The physician can make a difference. Two studies show substantial increase in child restraint device usage when a physician or nurse counsels or makes a personal recommendation.<sup>9,16</sup>

There is a modest rise in car seat use in states that have a legal requirement to use restraints.<sup>11,12</sup> A study in Rhode Island showed that use climbed 13% four months after that state's statute became effective. While this is not a massive turn toward use of restraints, it represents a 50% increase from use one month prior to the effective date of the act. The law, when coupled with more individualized education such as parenting classes and counseling by physicians, will produce substantial results.

To date, sixteen states have enacted mandatory child restraint statutes. In addition, Nebraska requires restraints be provided only by persons or businesses furnishing child care. Three other states have enacted statutes establishing a \$25 tax credit which can be taken when a child seat is purchased.

Six states, including Illinois, and the District of Columbia have bills pending which would require the use of child restraints.

In Illinois, House Bill 608, the Illinois Child Passenger Safety Act, has been under debate for eighteen months. The cost of that debate has been high: in that time, 25 children under five died in auto accidents and 3700 more were seriously injured.<sup>17</sup>

The bill has been passed by both the House of Representatives and the Senate, and the governor returned an amendatory veto for their consideration on September 17. While it will not be possible to predict the final form in which it will pass,\* the version approved by the governor and now under consideration in the veto session would require that parents of children under age

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*\*Editor's Note: Any changes in these provisions during the winter veto session will be reported in an upcoming issue of IMJ, under the "Doctor's News," column.*

two during 1983 and under age five thereafter restrain their children in federally approved child restraints unless the child is unusually large, in which case seat belts must be used. The law would take effect June 1, 1983, and a first offense would carry a warning; each offense thereafter would carry a \$25 fine. Offenses are not moving violations.

Several loopholes exist in this bill: first, the proper use of belts holding the seat in the car is not required. Second, nonparent drivers are not required to restrain children, which presents obvious safety and enforcement problems.

In its defense, it is important to note that compromise is essential to the passage of any bill. Groups supporting child restraint use point out that legislation is only the first step toward substantial use.<sup>18,19</sup>

## Summary

Traffic accidents are the leading cause of death in children over one year of age. Although legislation, such as the mandatory child restraint law, (HB 608) will set public policy towards child restraints, it will be difficult to enforce. Therefore, the personal counseling by physicians, nurses, and other health care personnel, in addition to the legal mandate, will be required to implement utilization of child restraints by parents. ◀

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A Survey Among Hospitalized Psychiatric Patients

The Perils of Polypharmacy And Copharmacy

BY V. SIOMOPOULOS, M.D. AND ANIL GODBOLE, M.D.

Surveys of psychotropic drug use among hospitalized psychiatric patients have shown that polypharmacy, the simultaneous use of many drugs, is very common.<sup>1-3</sup> These studies have generally critical of polypharmacy, but they have themselves been criticized. It has been said that the studies are limited to what treatment has been prescribed and virtually neglected reasons for that treatment and circumstances.<sup>4</sup>

Recently the term "copharmacy" was introduced to indicate the simultaneous use of several different classes of drugs when the physician aims at removing certain well-defined target symptoms (e.g., depression and psychotic symptoms).<sup>5</sup> We suggest that the term "copharmacy" may also be used when more than one pathological condition is being treated (e.g., schizophrenia and epilepsy, depression and hypertension).

Obviously, the boundaries between polypharmacy and copharmacy are not always well drawn. Polypharmacy may overlap with copharmacy. What one physician may consider copharmacy another may call polypharmacy. It is generally recognized that simultaneous use, justifiable or

Table 1 Frequency of Polypharmacy and Copharmacy and Their Adverse Reactions (N = 601)			
Drugs combined	Number of patients with polypharmacy and copharmacy	Number of patients with adverse reactions	%
3 or more psy- chotropic drugs combined with 1 or more interact- ing non-psycho- tropic drug	70	49	70.0
2 psychotropic drugs combined with 1 or more interacting non- psychotropic drug	31	15	48.3
Total	101	64	63.3

**ANIL G. GODBOLE, M.D.**, is a board certified psychiatrist and chairman of the department of psychiatry at the Ravenswood Hospital Medical Center, Chicago. An examiner for the American Board of Psychiatry and Neurology, Dr. Godbole is also affiliated with Barclay Memorial, Lakeshore and Weiss Memorial hospitals in Chicago. He is a former co-director of the stress management service (biofeedback and desensitization) for the Field Medical Group, Chicago where his private practice is located.

**VASILIS K. SIOMOPOULOS, M.D.**, is a clinical associate professor of psychiatry affiliated with the UI Abraham Lincoln School of Medicine. He is affiliated with the Ravenswood Hospital Medical Center, Chicago and St. Francis Hospital, Evanston. Dr. Siomopoulos has served as a staff psychiatrist for the Illinois State Psychiatric Institute and is the director of the inpatient psychiatric unit for Ravenswood. Also at Ravenswood, Dr. Siomopoulos is chairman of the audit and treatment review committee and member of the classification and advisory committee.

not, of several interacting drugs results in inability to assess therapeutic effects and adverse reactions of each and increases the risk of adverse reactions. This study is a survey of adverse reactions observed among hospitalized psychiatric patients treated simultaneously with several interacting drugs of the same or different class.

Method

The study was conducted at a general hospital with a 32-bed inpatient psychiatric unit. Records of all 601 admissions to the psychiatric unit within the one-year-period preceding the study were reviewed. The review included study of physician's orders and progress notes, nursing notes, notations of blood pressure and pulse rate (taken routinely four times daily) and consultation and laboratory reports. Systolic blood pressure <90mmHg was considered hypotension. Daily fluctuations of blood pressure of 4mmHg or more were recorded as "blood pressure fluctuations." Pulse rate >100/min. was considered tachycar-

Table 2 Age Distribution of Polypharmacy and Copharmacy and Their Adverse Reactions (N = 601)				
Age	Number of patients with polypharmacy and copharmacy	%	Number of patients with adverse reactions	%
<20	1		1	
20-39	47	46.5	29	61.7
40-59	28	27.1	13	46.4
>60	25	24.7	21	84.0
Total	101	16.8	64	63.3

dia. The study included all prescribed psychotropic drugs (antipsychotics, antidepressants, antianxiety drugs, lithium) and all other non-psychotropic drugs concomitantly prescribed and known to interact with the above. PRN medications were not included in the study.

## Results

Polypharmacy and copharmacy were found in 101 cases (16.8%). Adverse reactions were noted in 64 of these cases (63.3%). Table 1 shows analysis of these figures according to the number of drugs prescribed. When two psychotropic drugs were combined with one or more interacting non-psychotropic drug, the percentage of patients with adverse reactions was 48.3%. However, when three or more psychotropic drugs were combined with one or more interacting nonpsychotropic drug, the percentage of patients with adverse reactions rose to 70.0% ( $X^2 = 4.32$ ,  $p < .05$ ).

Table 2 shows age distribution of polypharmacy and copharmacy and their adverse reactions. The lowest incidence of polypharmacy was found in the age group over 60 (24.7%), but the incidence of adverse reactions in this age group was, as expected, very high (84%). The most commonly noted adverse reactions were tachycardia, hypotension and/or blood pressure fluctuations and drowsiness (Table 3). Antiparkinsonian and antihypertensive drugs were the most commonly prescribed non-psychotropic drugs (Table 4). Table 5 provides detailed information about some severe adverse reactions observed, *i.e.*, two cases of central anticholinergic syndrome, one case of toxic (nonanticholinergic) encephalopathy and one case of sudden death.

## Discussion

Psychotropic drugs may interact with each

Table 3 Adverse Reactions Associated With Polypharmacy And Copharmacy (N = 101)	
Type of reaction	Number of patients with reaction
Tachycardia	20
Hypotension and/or blood pressure fluctuations	20
Drowsiness	19
Slurred speech	5
Tremor	3
Akathisia	3
Blurred vision	2
Dizziness	2
Ataxia	2
Central anticholinergic toxicity	2
Toxic encephalopathy (non-anticholinergic)	1
Sudden death	1
Seizures	1
Fecal impaction	1
Urinary retention	1
Oculogyric crisis	1
Nasal congestion	1

Table 4 Frequency of Administration of Non-Psychotropic Drugs Combined and Interacting With Psychotropics (N = 101)	
Type of drug	Number of cases
Antiparkinsonians	97
Antihypertensives	54
Anticonvulsants	15
Antihistaminics	10
Agent used to treat thyroid disease	6
Antacids	6
Others	5

other or other (nonpsychotropic) drugs to produce, in addition to their specific behavioral effects, multiple physiological changes. Antipsychotic, antidepressant and antiparkinsonian drugs have additive anticholinergic effects. This may result in minor adverse reactions, such as dry mouth, constipation, sweating, and blurred near vision, or more serious ones, such as increased intraocular pressure, paralytic ileus, urinary retention, arrhythmias and even signs of



**Table 5**  
**Some Severe Adverse Reactions Associated With Polypharmacy and Copharmacy**

Age/ Sex	Drugs Combined	Medical Problem(s)	Adverse Reactions	Nature of Adverse Reaction
F/25	Thioridazine (Mellaril) 200 mg qid Desipramine (Norpramin) 225 mg qd L-triiodothyromine (Cytomel) 25 mg qd Benztropine (Cogentin) 1 mg qid Flurazepam (Dalmane) 30 mg hs	Hypothyroidism	Confusion Disorientation Visual hallucinations ONSET: Two days after patient was placed on recorded doses of Mellaril and Norpramin. It subsided after Norpramin was discontinued and Mellaril was replaced by Stelazine 5 mg qid.	Central anticho- linergic syndrome
F/32	Fluphenazine (Prolixin) 5 mg qid Thioridazine (Mellaril) 300 mg qd Fluphenazine (Prolixin decanate) 25 mg I.M. q14 days L-triiodothyronine (Cytomel) 25 mg hs Benztropine (Cogentin) 2 mg bid Chlorthalidone (Hygroton) 50 mg qd	Hypothyroidism Hypertension	Hypotensive episode (BP 78/64) followed by sudden death within 3 hours while patient was asleep.	Circulatory col- lapse. Autopsy findings: passive conges- tion of liver, lungs & kidneys.
F/27	Thioridazine (Mellaril) 100 mg qid Chlordiazepoxide-amitriptyline (Limbitrol) 10-15 qid Diphenhydramine (Benadryl) 25 mg qid Amantadine (Symmetrel) 100 mg bid	None	Confusion Disorientation Dysarthria Lethargy Symptoms cleared up when all medications were discontinued.	Central anticho- linergic syndrome
F/56	Haloperidol (Haldol) 5 mg tid Methimazole (Tapazole) 10 mg tid Propranolol (Inderal) 20 mg bid Cimetidine (Tagamet) 300 mg qid	Hyperthyroidism Hypertension Peptic ulcer	Hyperpyrexia (103°F); Seizures; Diaphoresis; Cold and clammy skin; Dilated pupils, inconti- nence of urine and feces; Coma. EEG: Slow waves suggestive of encephalopathy; symptoms sub- sided within 3 days when above medications were discontinued.	Toxic encephalo- pathy

central atropine-like anticholinergic poisoning, *i.e.*, restlessness, agitation, confusion, disorientation, dysarthria, seizures and hyperthermia, and visual hallucinations (central anticholinergic syndrome).

Minor anticholinergic reactions are very common among patients receiving antidepressant, antipsychotic or antiparkinsonian drugs alone or combined with each other. The low incidence of such reactions among the patients of our study should be attributed to under-reporting by the patients and under-recording by the nursing staff. On the other hand, the more serious anticholinergic reactions (urinary retention, fecal impaction, tachycardia, central anticholinergic toxicity)

are, because of their severity, more readily reported, observed and recorded. Their incidence among the patients of our study should be seen as reflecting actual incidence among this patient population.

Severe adverse reactions not associated with the anticholinergic properties of these drugs were one case of sudden death, one case of seizures, and one case of toxic encephalopathy.

Sudden death has been reported among patients receiving antipsychotics or antidepressants and causal relationships between these drugs and the occurrence of death have been postulated. Profound hypotension, cardiac arrhythmias, aspiration, and extreme hypothermia or hyperthermia

have been implicated as possible mechanisms of these deaths.<sup>6</sup> In our case, sudden death occurred within three hours after a hypotensive episode while the patient was asleep. The observed hypotension should be attributed to the combination of a diuretic antihypertensive drug (chlorthalidone) with two antipsychotic drugs (thioridazine and fluphenazine), a combination that is known to enhance the hypotensive effect of both classes of drugs.

Another severe adverse reaction observed was the development of toxic encephalopathy by a patient receiving cimetidine, haloperidol, propranolol and methimazole. Central nervous toxicity has been observed among patients receiving low-dose propranolol therapy<sup>7</sup> as well as among patients receiving cimetidine in combination with psychotropic drugs.<sup>8</sup> These findings are particularly worth noting in view of the wide use of both propranolol and cimetidine in general medical practice.

In conclusion, the authors wish to emphasize that the increased incidence of adverse reactions among the elderly and the potentially lethal effects of psychopharmacotherapy among those with compromised cardiovascular system will demand, as pointed out by Ayd,<sup>9</sup> a "rational" pharmacological treatment approach to the psychiatric disorders of these patients. ◀

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# Case Reports

## Post-Cholecystectomy Retained Gallstone In An Abdominal Sinus Tract

BY CARL DAVIS, JR., MD, FACS/CHICAGO

On occasion, a surgeon is called upon to treat operative wounds in patients whose surgery was performed by another physician. In a discussion of wound healing, Reid<sup>1</sup> emphasized that a "thorough knowledge of healing of wounds will lead to a more intelligent practice of our art, as well as to greater perfection in it." Harkins<sup>1</sup> stated that "the knowledge of wound healing is the central core of the science of surgery; in fact, surgery is dependent upon wound healing for its very existence."

This paper is concerned with the history and findings, as well as surgical treatment, of postoperative wound complications in an elderly female patient who had had an elective cholecystectomy two years before. Recurrent bouts of infection had developed in the operative wound over a period of months. Nu-

merous treatments were instituted, including multiple incision and drainage procedures, administration of ampicillin and infrequent cauterization of granulation tissue, but these measures failed to promote satisfactory wound healing. It is of interest that Peterson<sup>2</sup> in a discussion of delayed wound healing, stated that "local factors which delay wound healing place a premium on surgical craftsmanship and the operative techniques used in wound care."

### Case Report

An 87-year-old white female with history of insulin treated diabetes was admitted for investigation and treatment of a long standing, draining sinus tract of the abdominal wall. This condition had been first experienced after an elective cholecystectomy through a right subcostal incision two years before. It was reported at surgery that a chronically infected gallbladder was found with evidence of acute hemorrhagic ulcerative cholecystitis. An abscess was found between the gallbladder and the liver. Cholecystectomy was performed with drainage.

The immediate postoperative course was described as uneventful. Eight months post-operatively, an abscess appeared in the old operative wound. Incision and drainage were performed. The wound healed. A

year after surgery, another infection was observed in the region of the operative incision. Incision and drainage were again performed. On one occasion, two fragments of wire utilized in the original wound closure were removed. Granulation tissue was cauterized on numerous occasions in order to enhance wound healing.

On admission, examination revealed a cheerful, stout female, 87 years of age, who did not appear acutely ill. Her general health was good except for a history of insulin treated diabetes. The general physical examination was essentially normal except for the abdominal findings. Temperature was 98.6. The abdomen was rotund. In the right upper quadrant of the abdomen in the center of the old Kocher incision, the opening of a draining sinus tract and semi-purulent drainage were noted. Neither leukocytosis nor anemia were present. Cultures of the wound showed *E. Coli* organisms. A roentgenographic examination of the abdomen demonstrated multiple fragments of wire in the region of the operative site. Presence of these metallic foreign bodies suggested a plausible reason for the recurrent infections in the cholecystectomy wound.

Preoperative preparation consisted of appropriate management of the uncontrolled diabetes, administra-

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**CARL DAVIS, JR., M.D., F.A.C.S.,** is a board certified surgeon affiliated with Rush-Presbyterian-St. Luke's, Augustana and Skokie Valley hospitals in the Chicago area. An associate clinical professor of surgery at Rush Medical College, he is also an associate clinical professor in surgery and graduate faculty member at the UI Medical School, Chicago. Dr. Davis' many professional activities include an interest in medical motion pictures.

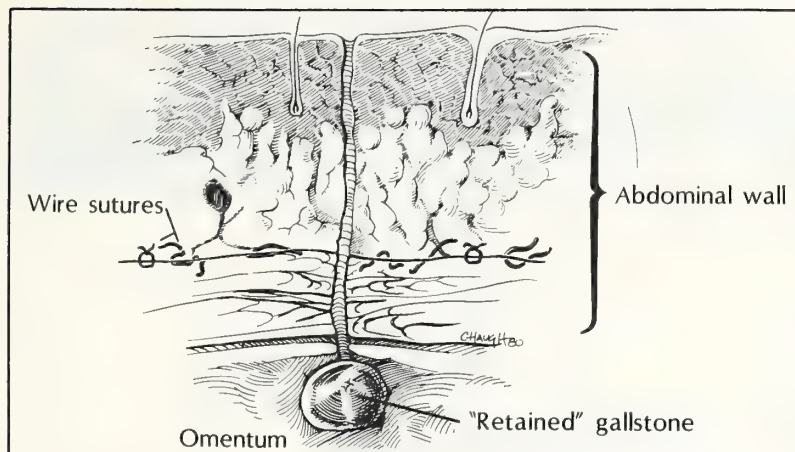


Figure 1A

Artist's conception of the sinus tract of the abdominal wall demonstrating the wires in the external oblique fascia and the "retained" gallstone found lying just within the peritoneal cavity.

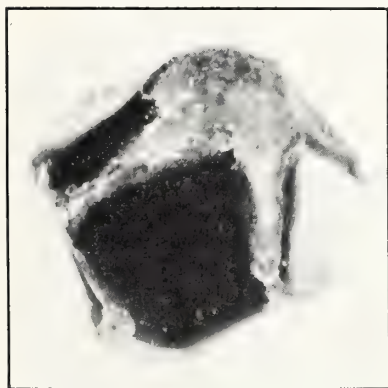


Figure 1B

This photograph illustrates the multifaceted, greenish black stone of mixed composition (1 cm. in diameter).

tion of ampicillin, and local application of hot compresses to the wound. At surgery, under general anesthesia, a small probe was readily passed into the sinus tract. The entire operative scar was excised. Multiple wire sutures were found in the fascia and removed. Further dissection of the sinus tract disclosed a deep seated multifaceted, dark green gallstone of mixed composition, about 1cm. in diameter. This was easily removed. (Figures 1A and B) Excision of the sinus tract followed. The wound was closed with loosely tied fine sutures.

A small drain was left in place. Wound healing progressed as ampicillin therapy was administered and the diabetes was controlled.

The patient was discharged from the hospital one week after admission to convalesce at home. A recent communication from the patient, now 89 years of age, indicated that the wound has remained healed over a two year period.

## Discussion

It has been stated by Stone<sup>3</sup> that postoperative wound infections are one of the most common complications of abdominal surgery. Stone<sup>4</sup> further suggested that operations for acute cholecystitis, in the presence of infected bile, can be expected to result in a different incidence of wound infection involving different organisms than elective cholecystectomy for chronic cholecystitis.

Noer<sup>5</sup> pointed out that "contamination probably occurs in all wounds, but infection occurs only if the dosage and virulence of the organisms are so related to the resistance of the host that growth and multiplication of the bacteria can result in infection." He indicated that if the inflammatory process should continue after adequate drainage, "careful search must be made by every means available in the hope of finding and removing the foreign material which may well have caused the development of infection in the

first place." Of course, roentgenograms of the abdomen, either routine AP and lateral films or a CT scan, should be utilized before exploration.

The problems involved in the treatment of this case concern an elderly, obese female with uncontrolled diabetes. She had had an elective cholecystectomy for chronic cholecystitis and cholelithiasis. The wound was potentially infected as a result of possible contamination from an abscess found between the liver and gallbladder.

Some months later, a wound infection appeared complicated by the presence of a persistent sinus tract of the abdominal wall. Surgical exploration of the old operative wound, under general anesthesia, revealed numerous wire sutures in the external oblique fascia. A totally unsuspected finding was a retained solitary, multifaceted gallstone of mixed composition found at the bottom of the tract just within the peritoneal cavity. The preoperative roentgen findings of the wire sutures in the abdominal wall prompted the initial consideration that these foreign bodies were the precipitating factor in the development of the wound infection.

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# Illinois Society, American Association of Medical Assistants

## National Meeting Highlights

Approximately 35-40 advisors, members and guests from Illinois attended the recent American Association of Medical Assistants annual meeting in Houston, Texas.

Among them were Dr. and Mrs. Robert R. Hartman. Dr. Hartman, a native of Jacksonville, has been an AAMA advisor since 1981 and our Illinois State Medical Society liaison, since 1978. More than 1,200 physicians serve as advisors to AAMA nationally. Dr. Hartman has held many offices and chaired many committees during his years with Illinois State Medical Society. We, in Illinois Society, appreciate his experience and willingness to work with us and hope this association continues for many years.

Illinois Society speaker, Luella V. Mitchell, CMA, was elected AAMA speaker of the house. She has been a medical assistant and office manager for a general surgeon for the past 36 years. Constant self improvement coupled with the continuing education courses offered by AAMA have contributed to her leadership abilities. Her

candidacy for speaker received widespread support from every level of AAMA. Illinois Society is indeed pleased to honor this member.

Janet Binkowski, RN, President of Illinois Society, was elected to the 1982-83 Nominating Committee for AAMA. Her job will be to ensure that qualified members are on the slate for elective offices in 1983.

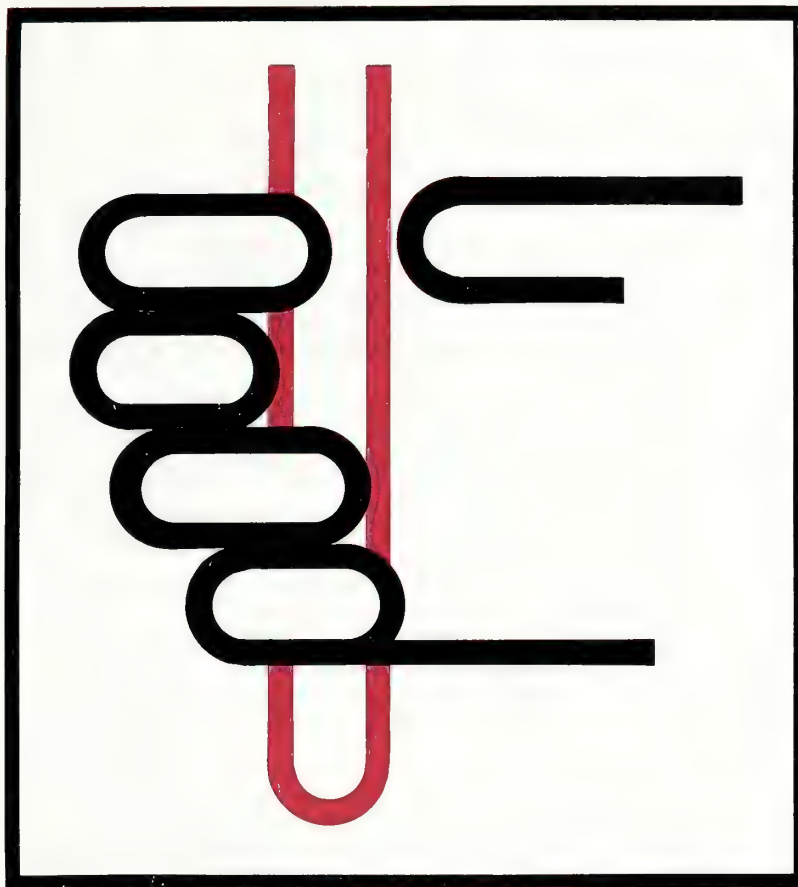
Mary Frances Burton and Cissy Egly were appointed to serve on AAMA committees for the coming year and we wish them well.

Our annual meeting was distinguished, among other things, by its emphasis on education and the desire to build a more united organization. Emphasis was placed on membership retention, certification and revalidation after five years.

Information regarding Illinois Society, AAMA may be obtained from Janet Binkowski, R.N., President, Illinois Society, 428 Adams Street, Dolton, IL., 60419 or Ruby Jackson, CMA, chairman, Public Relations Committee, 7337 South Shore Drive, Chicago, IL 60649. ◀

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## Abstracts of Board Actions

(Continued from page 407)

Additionally for 1983, various programs were reviewed and the following actions taken to begin preparations for the next budget:

- Begin negotiations, after January 1, 1983, with the specialty societies for reimbursement of direct and indirect expenses of staffing their activities.
- Provide a \$29,600 subsidy to the Auxiliary, beginning in 1983.
- Reduce Action Report to 4 or 5 issues and develop and implement a public aid newsletter on a request basis.
- Continue to support a State Fair booth and seek outside funding if possible.
- Continue Impartial Medical Testimony and Workers Compensation Panels and begin negotiations with Illinois Courts and Industrial Commission to recover costs of this activity.
- Discontinue the Allied Health Symposium in 1983 and recreate a Task Force on Allied Health.
- Provide up to \$10,000 for programs in support of hospital medical staffs through county medical societies.
- Reduce funding for Past Presidents Dinner by \$2,000.
- Endorse Migrant Health Program if grant funding is obtained.
- Continue Worker's Compensation Program for Medical Assistants and Program on Adolescent Health Problems with registration fees to partly offset costs.

Related to this, the Board requested a report from the Sports Medicine Committee on the utilization of monies budgeted for its activities. The Executive Committee is to further study the matter of a Washington Roundup.

In response to previous House action, the Board authorized that the 1983 dues billing statement include a combined voluntary contribution line for IMPAC/AMPAC.

Also considered, and referred to the Executive Committee for further study and report, was the question of accepting credit card payment of membership dues with prior approval of county medical societies.

### DRUGS AND THERAPEUTICS

Acting on recommendations from the Committee on Drugs and Therapeutics the Board voted to:

- Include the following drugs in the IDPA Drug Manual: Fulvicin 165 mg., Fulvicin 330 mg., Proventil & Ventolin, Cyclocort, Heptavax-B and Nordette.
- Not include the following drugs in the IDPA Drug Manual: Oralflex, Surmontil, Theo-Dur Sprinkle, Accutane and Neggram in the strengths of 250 mg., 500 mg., 1 gm. and 250 mg/5ml. suspension.
- Remove Fulvicin 125 mg. and Fulvicin 250 mg. from the IDPA Drug Manual.
- Add Methenamine Mendelate Tab 0.50 gm. & Methenamine Mendelate Tab 1.00 gm. to the IDPA Basic Health Protection Plan of approved drugs.

### CHILD SAFETY RESTRAINTS

In an ongoing review of the public health issue relating to safety of children in automobiles, the Board authorized procedures for distribution of child safety restraint brochures.

- Publish information about brochure availability in the *Illinois Medical Journal* and Action Report for the membership;
- Inform Illinois parent teacher organizations about the brochure, providing a single copy as an example;
- Allow individuals and organizations to receive brochures;
- Provide single copies of the brochure without charge;
- Provide brochures in quantities (*i.e.*, 50, 100 and 500) and charge for costs involved in publication and mailing.

## **JCAH STANDARDS**

Various revisions in JCAH standards are proposed periodically. The Board is apprised of these for purposes of review and comment. A current proposal modifies the standards to permit a hospital to develop a "professional" staff. The medical staff would be a unit within this. Based upon a concern that provision of medical services must be under the direction and supervision of physicians, and to maintain a cohesion and continuity in patient care, the Board opposed the concept of a "professional" staff including persons licensed to practice professions other than medicine. A position paper was reviewed and referred to legal counsel for his opinion. Upon counsel's review, the Board directed that the ISMS position be communicated to the JCAH.

## **FINANCIAL AID TO MEDICAL STUDENTS**

A report on current activities to develop a student loan fund in the ISMS Educational & Scientific Foundation was received by the Board. To enhance the availability of funds for loans, the Board agreed to sponsor and support an auction, conducted by the Auxiliary, at the 1983 Annual Meeting.

## **HOUSE OF DELEGATES RESOLUTIONS AND REPORTS**

Acting upon review and recommendations from various councils and committees, the Board acted to introduce several resolutions to the Interim Session of the House of Delegates on November 12, and to provide Old Business reports on resolutions which had been referred to the Board at the 1982 Annual Meeting.

### *Resolutions:*

- The Board approved a resolution entitled "Amendments to Chapter IX. Committees" that would amend the bylaws to provide for the Peer Review Appeals Committee to be included in Committees Reporting Directly to the Board, for the Speaker of the House of Delegates to be listed as an ex-officio member of the Executive Committee and for the listing of the CME Accreditation Appeal Panel along with its function.
- Also approved was a resolution to oppose an AMA activity. This resolution is titled "AMA Section for Hospital Medical Staffs."
- A resolution entitled "ISMS Policy Statements on Hospitals" was approved for submission to the House of Delegates.
- Another resolution, "Amendment of Policy Manual Statement on Informing the Membership" was approved for submission to the House of Delegates.

### *Old Business reports will be submitted to the House, as the Board of Trustees:*

- Agreed to advise the House of Delegates that Res. 1 (A-82) "Liability Insurance Costs" not be adopted.
- Agreed to advise the House of Delegates that Res. 13 (A-82) "Monitoring UR Activities" be adopted with an amendment.
- Deferred action on Resolution 15 (A-82) until a final decision on the American Academy of Family Physicians' lawsuit against the Michigan Medicare Carrier, for fee discrimination on the basis of medical speciality, is reached.
- Authorized counsel to review the legal ramifications of Res. 23 (A-82). If legal counsel determines that it is appropriate to proceed with action, the Council on Economics would study the resolution and report its recommendations to the Board of Trustees at a later date. If legal counsel determines that it is not appropriate to proceed with action, the Board would so inform the House of Delegates.

## **OTHER ACTIONS**

In other actions, the Board:

- Referred to the Medical-Legal and Governmental Affairs Councils a recommendation that ISMS propose legislation or regulations to place a line on the Illinois



driver's license application form which indicates that by applying for the license the applicant, if arrested, consents to a blood or other chemical test by a physician or other qualified person who is requested by a law enforcement officer to administer such a test. This was raised by questions from the membership regarding the new drunk driving law.

- Adopted a revised statement of purpose for the ISMS Committee on Third Party Payment Processes Committee.
- Directed that the Task Force on Membership communicate the assistance available for ISMS members regarding their problems with third party payors.
- Ruled that "Hold Harmless" complaints from members be directed to the Third Party Payment Processes Committee for discussion and recommendation for Board of Trustees action.
- Approved revisions in the *Illinois Medical Journal* advertising rates.
- Adopted procedures for *Illinois Medical Journal* advertising discounts by which advertisers would be informed that the 2% discount for early payment will not be honored after a 10-day limit.
- Directed that the Third Party Payment Processes Committee provide liaison to Blue Cross/Blue Shield.
- Authorized purchase of a medical emergency bag to be available at ISMS meetings, and procedures by which this will be available for use.
- Agreed to: (A) Provide a summary of the "Care of the Athlete" course to county medical societies informing them of its availability and encouraging them to inform their members of the benefits of such programs; and (B) Place a notice in the *Illinois Medical Journal* for individual physician members interested in conducting a sports medicine program through their county medical societies.
- Approved: (A) ISMS participation with IDPH in conducting a survey on adolescent health problems; (B) Requesting assistance from the Illinois Board of Education (IBE) in identifying public and private schools; and (C) Securing IBE participation.
- Authorized: (A) Development of a working definition of a Health Care Coalition for submission to the Board; and (B) Obtaining an inventory of the Health Care Coalitions in Illinois.
- Agreed to respond to an IDPH Request for Proposal (RFP) seeking technical assistance for family planning agencies which contract with IDPH. These agencies are primarily county and/or city public health departments and are reimbursed for their family planning services through the Title XX Social Services Block Grant. The proposed grant would provide technical assistance to nineteen designated family planning agencies in Illinois.
- Agreed to join with the Chicago Medical Society sponsoring a fund raising dinner to be held at the Museum of Science and Industry with the earnings to be used for upgrading the exhibit of CMS, ISMS and AMA which was donated to the Museum in 1969.
- Received an information report on the Governor's Medicaid Conference August 31.
- Modified the price list of ISMS mailing labels to allow use by County Medical Societies in membership procurement, at no charge.
- In keeping with a resolution (11 A-82) providing a mechanism for legal counsel review of House actions, the Board directed that the procedures be included in the Policy Manual.
- Adopted modifications in the listing of ISMS goals and objectives as part of a continuing review of ISMS priorities, as recommended by the Planning and Priorities Committee.
- Approved continuance of the employee's dental insurance plan with Illinois Dental Service.
- Approved a change in coverage and carrier for accidental death and dismemberment insurance covering persons engaging in ISMS activity at a premium savings of over \$4,500 per year.

## PROGRAM SPONSORSHIP

In review of requests for programs, the Board:

- Ratified the co-sponsorship of the following programs (with no commitment of ISMS resources):
  - Doctors' Job Fair, Springfield, September 10, 1982
  - Ill. Child Passenger Safety Assoc., Peoria, September 10, 1982
  - American Society of Law & Medicine, Chicago, November 11, 1982
- Approved an ISMS Sports Medicine Program to be held: (A) At the 1983 Midwest Clinical Conference; and (B) In the fall of 1983 at a downstate Illinois location.
- Authorized development of an ISMS program to build membership among medical academia and concomitantly offer programs of value to medical school faculty.

## NOMINATIONS AND APPOINTMENTS

Various nominations and appointments were acted upon, as the Board:

- Ratified the appointment of Dr. Harry Lewis, Benton, to the Peer Review Appeals Committee.
- Ratified the following nominations: Drs. Kofi Amankwah, Robert Hartman, Ronald Welch, Leonard Rybak and William Wehrmacher to the AMA Diagnostic and Therapeutic Technology Assessment program; Drs. Herbert Natof and Dale Rosenberg to the IDPH Ambulatory Surgical Treatment Center Licensing Board; and Dr. Richard Banta to the IDMHDD Citizens Advisory Committee on Alcoholism.
- Endorsed Drs. Vincent A. Costanzo and Dorothy H. Hubler for reappointment to the IDPH Technical Advisory Council of the Drug Product Selection Program.

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“Government is not reason, it is not eloquence . . . it is force.  
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never for a moment should it be left to irresponsible action.”

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Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, & 110.5 (Federal Regulations require this notice.) IMPAC reports are filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois, 62704. Voluntary membership contributions support political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC.

# Doctor's News

**PHYSICIANS IN THE NEWS—Katharine W. Wright, M.D.**, Chicago, founder of the Katharine W. Wright Psychiatric Clinic of Illinois Masonic Medical Center, celebrated her 90th birthday at a surprise luncheon given in her honor by their department of psychiatry. **Fred A. Tworoger, M.D.**, Chicago, past president of the Chicago Medical Society and ISMS delegate to the AMA, has joined the staff of the 7-Mile Clinic in Winter Park, Colorado.

**CME FALSIFICATION WARNING**—The Illinois Department of Registration and Education Medical Examining Committee has announced that physicians who falsify their re-licensure applications are in violation of the Medical Practice Act and will be referred to the Department's Medical Disciplinary Board. Records show that a number of physicians have stated that they have met the CME requirement when, in fact, they had not completed all or some of the required 100 hours.

**ASTHMA SERVICE**—A new asthma service at the University of Chicago Medical Center offers around the clock medical assistance for asthma victims. A pulmonary medical specialist on call 24 hours a day can interpret a reading from an asthmatic's peak flow meter, a diagnostic device asthmatics carry. By altering the patient's medication the specialists can help to relieve the patient's problem which can be done over the phone, eliminating trips to the hospital. For more information, call the Asthma Service at (312) 947-2683.

**TRAUMA SYMPOSIUM**—Trauma Care '83, the National Symposium on trauma, will be held at the Scottsdale Hilton Hotel, Scottsdale, Arizona January 8-13, 1983. Sponsors for the event are John C. Lincoln Hospital and Health Center, Lincoln Institute of Surgery and Trauma (LIST) and Emergency Medical Consultants (EMC). For more information contact: Trauma Care '83, Robert J. Rankel, M.D., Chairman, c/o John C. Lincoln Hospital and Health Center, 921 North Second St., Phoenix, Arizona 85020 or call (602) 943-2381 ext. 1736.

**HOSPITAL, WHOLESALE AND RETAIL TYLENOL CUSTOMERS**—Due to the tampering of Extra-Strength Tylenol Capsules, McNeil Consumer Products Company has announced the following policy: In agreement with the FDA, McNeil Consumer Products Company is voluntarily withdrawing all non-blistered TYLENOL® capsule products (including Regular Strength TYLENOL® Capsules, Extra-Strength TYLENOL® Capsules, non-blistered CoTYLENOL® Capsules, and Maximum-Strength TYLENOL® Sinus Medication Capsules) from hospital, wholesale and retail accounts nationally. *Hospital unit dose packaging and physician samples in sealed pouches containing two capsules each are not being withdrawn since they are temper-resistant.* In addition, McNeil Consumer Products Company is advising all TYLENOL capsule users to now use TYLENOL tablets until cpsules in temper-resistant packages are available. Consumers are urged to return all TYLENOL capsule products to the place of purchase, or to mail bottles to Tylenol Exchange, P.O. Box 2000, Maple Plains, Minnesota 55348. They will receive TYLENOL tablet products in exchange or alternatively a cash refund for unused capsules.



**NEW USAN BOOK LISTS DRUG NAMES**—The 1983 edition of *USAN and the USP Dictionary of Drug Names* has been published by the United States Pharmacopeia Convention. This 20th anniversary edition of the dictionary contains all U.S. Adopted Names (USAN) released from June 15, 1961 through June 15, 1982.

In addition, the book includes all international nonproprietary names (INN) published by the WHO from 1951 through 1981 which represent 4197 INN, over 2300 graphic formulas relating to INN and more than 5100 brand names of research-oriented firms, 2650 investigational drug code designations, official names of USP XX and NF XV articles with their chemical names and graphic formulas, and other names for drugs.

To order the new edition of *USAN/USP-DDN* send \$35.00 per copy to the USAN Division, USP Convention, Inc., 12601 Twinbrook Parkway, Rockville, MD 20852. Discounts are available when ordering 11 or more copies.

**DMSO CONTROVERSY**—The safety and efficacy of dimethyl sulfoxide (DMSO), when used for medicinal purposes, is still under controversy according to a recent AMA news release. DMSO, used experimentally to treat arthritis, gout and various infections in the mid-60s, is legally manufactured and prescribed by special legislation in some states, despite lack of Food and Drug Administration approval or medical support.

Questions arose in the 60s as to whether or not DMSO caused toxic effects in humans. However, in 1980 the FDA relaxed its restrictions on clinical testing and permitted resumption of investigations in the potential usefulness of the drug.

Results of the studies may not be available for months. According to AMA, the FDA and Arthritis Foundation have warned physicians and the public of the potential hazards of using the industrial product, one available form of DMSO, which may carry impurities through the skin.

**INTRACTABLE RHEUMATOID ARTHRITIS TREATMENT**—Experiments with a combination of drugs have been successful in controlling severe rheumatoid arthritis in a small group of patients, according to a recent AMA news release. Fourteen of 17 patients improved after being treated experimentally, at the Medical College of Wisconsin in Milwaukee. Three drugs, hydroxychloroquine, cyclophosphamide and azathioprine, were given to the 17 patients, who had been resistant to conventional drug treatment. The use of these three drugs to treat intractable rheumatoid arthritis will be further tested in controlled clinical trials.

**PATIENT DRUG INFORMATION PROGRAM**—Patient Medication Instructions (PMIs) are now available to physicians for distribution to patients through a voluntary program initiated by the American Medical Association. According to a recent AMA news release, PMIs may help patients comply with instructions for taking prescribed medications and improve the effectiveness of therapy.

PMIs for 20 widely prescribed drugs are now available for a nominal shipping fee from the AMA. The program will provide PMIs for up to 100 drugs in the near future. The PMI is a 5½" by 8½" sheet describing in simple language the purpose of the drug, how to take the drug and possible side effects. Space is provided for physicians to write any special instructions.

The PMI program, based on information from the *AMA Drug Evaluations* and the *United States Pharmacopeia*, is sponsored by the AMA Education and Research Foundation with support of donations from pharmaceutical firms.

**SCIENTIFIC/SKI MEETING**—The Northwestern Medical Association will hold its 36th Annual Meeting in Sun Valley, Idaho, February 7-11, 1983. Experts will discuss transplants-implants, ski-injury prevention, high altitude physiology and more. The event is approved for 10 CME Category 1 credits. Registration will be from 3:00-5:00 p.m. February 7 at the Challenger Inn, Sun Valley. For more information contact Norman Christensen, M.D., 2456 Buhne St., Eureka, CA 95501 or phone (707) 443-2248.



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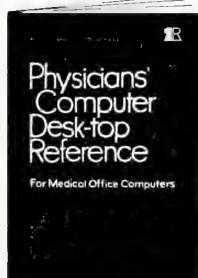
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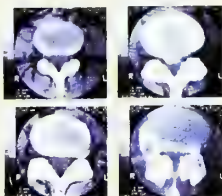
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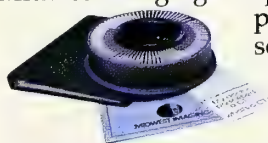
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## Viewbox

(Continued from page 399)

**Diagnosis:** (d) Percutaneous nephrostomy



**Figure 2A**

Antegrade pyelogram reveals multiple filling defects (arrows) in the right renal pelvis. Ureteral stent and nephrostomy catheter are also present.

Ultrasonography is an accurate and noninvasive way to screen for urinary tract obstruction. The coronal ultrasound (Figure 1) demonstrated a hydronephrotic right kidney and proximal ureter. The ureter could not be visualized below its upper one-third. A percutaneous nephrostomy was done with drainage of purulent, hemorrhagic fluid from the renal pelvis. Following catheter drainage for several days, an antegrade pyelogram (Figure 2A) showed the cause of obstruction to be a renal calculus. The patient had a previous



**Figure 2B**

Following two weeks of catheter infusion of an alkalinizing solution, the filling defects are no longer seen and the ureter is widely patent.

history of uric acid calculi and the present calculus was dissolved by catheter installation of an alkalinizing solution. (Figure 2B)

### Discussion

Percutaneous nephrostomy was first described in 1955<sup>1</sup> but 10 years elapsed before its next description in the literature.<sup>2</sup> Since 1965, it has been widely employed as either temporary or definitive treatment of supravescical urinary tract obstruction. It is a relatively simple and safe procedure with a high success rate and has all but replaced operative nephrostomy in institutions where it is performed.<sup>3</sup>

### Indications

Supravescical obstruction of known or unknown etiology in a patient with azotemia and/or infection is the most common indication for percutaneous nephrostomy. Percutaneous drainage is

often the simplest and safest method of initial management of obstructive renal failure because of the high morbidity and mortality associated with general anesthesia and surgery in this patient population.<sup>4</sup> Endoscopic removal of a ureteral calculus is an exception since it provides definitive therapy immediately at a relatively low risk. In a number of cases, the etiology of the obstruction will not be known at the time of presentation. In these cases, percutaneous diversion of the obstructed system allows time for more thorough investigation of the etiology.

In short term supravescical obstruction, percutaneous nephrostomy is often definitive therapy. Examples would include ureterovesical obstruction following ureteral implantation, obstruction due to post-operative edema, and neoplastic conditions likely to respond to radiation or chemotherapy. While sometimes considered a temporizing procedure, Stables, *et al.*,<sup>4</sup> found that percutaneous nephrostomy provided definitive therapy in 62% of their cases.

A patient with partial obstruction and superimposed infection is an ideal candidate for this procedure and results are often more rewarding than in the treatment of isolated obstructive azotemia. Such a patient often responds dramatically with resolution of septicemia and clearing of urine in a matter of hours.<sup>5</sup>

In the absence of azotemia or infection, surgical correction of the obstruction is accepted therapy. In several settings, percutaneous nephrostomy may be indicated. These include: (1) expected brief duration of the obstruction, (2) uncertain functional capacity of the obstructed kidney and (3) anatomical or pathological factors which preclude definitive therapy.

Variable results have been achieved in the treatment of ureteral and renal fistulae with percutaneous techniques. Results have been more encouraging when some degree of obstruction is present. In these cases, many fistulae have been reported to close spontaneously or decrease significantly in size, thus facilitating surgical correction.<sup>6</sup> We have treated two patients with postoperative ureteral fistulae by means of percutaneous urinary diversion with complete closure of the fistula in both cases.

Nephrostomy catheters may also be utilized to instill a variety of drugs into the collecting system and ureters. Uric acid calculi can be dissolved by urine alkalization via a nephrostomy catheter. Magnesium ammonium phosphate (struvite) calculi have been dissolved by catheter administration of hemiacidrin but this requires a two-catheter continuous irrigation system due to the potential toxicity of the drug.<sup>7</sup> Cystine stones can

Table I	
Indications For Percutaneous Nephrostomy	
1. Supravescical Urinary Tract Obstruction	(a) with azotemia (b) with infection (c) of expected short duration
2. Ureteral or Renal Pelvis Fistula	
3. Stone Manipulation	(a) extraction (b) drug therapy
4. Ureteral Stricture Therapy	(a) dilatation (b) stent placement
5. Miscellaneous:	(a) nephroscopy (b) biopsy (c) foreign body removal (d) chemotherapy for urothelial tumors

be dissolved with either an acetylcysteine solution or THAM-E.<sup>8</sup> There is also the potential for direct instillation of chemotherapeutic agents into the urinary tract for the treatment of inoperable urothelial tumors.

The recent availability of larger and safer teflon angiographic-type dilators now allows rapid dilatation of nephrostomy tracts to a size accommodating a 34 French catheter.<sup>9</sup> Calculi as large as 15mm in diameter can readily be extracted through such a tract with either conventional or steerable baskets. Additional applications include foreign body retrieval, nephroscopy, brush biopsy, and forceps biopsy.

An additional extension of percutaneous nephrostomy is the antegrade passage of guide-wires, catheters, and stents to treat ureteral strictures due to a variety of causes which are not amenable to retrograde endoscopic manipulation. Both conventional catheter stents and Gruntzig balloon dilators have been successfully used in stricture dilatation.<sup>6</sup> While early results have been extremely encouraging, too few dilatations have been performed to date to allow a critical evaluation of its effectiveness. Table I summarizes the various indications for percutaneous nephrostomy.

### Technique

A detailed description of nephrostomy technique is beyond the scope of this article. The interested reader is referred to two recent reports which describe in detail the two most commonly used techniques: modified angiographic technique<sup>3</sup> and the trocar-canula technique.<sup>6</sup>

At our institution we utilize the modified an-



giographic technique with combined fluoroscopic/sonographic guidance and have been successful in percutaneous catheter insertion in every case attempted. Reported success rate in the literature ranges between 90% and 100%. Baron, *et al*, have described a technique utilizing real time sonography alone as guidance with similar results.<sup>10</sup>

## Contraindications

Severe bleeding diathesis is the only absolute contraindication to the procedure. Possible contraindications include perinephric abscess, tuberculosis, and renal tumors. The former two have been successfully treated in the past. Even transplanted pelvic kidneys and horseshoe kidneys have been successfully treated with percutaneous techniques. Agitated or uncooperative patients are difficult to deal with and increase the risk of complications. In this group adequate sedation is essential to safely complete the procedure.

## Results and Complications

Through careful patient selection and meticulous attention to technique, safe and relatively risk free percutaneous nephrostomy can be accomplished in the vast majority of patients. We have achieved a 100% success rate and similar results have been reported elsewhere.<sup>3,4,6,10</sup>

No fatality directly related to this procedure has been reported, and this compares most favorably with operative nephrostomy. Major complications occur in about 4% of patients<sup>4</sup> and include symptomatic infections/septicemia, severe hemorrhage, and urinary leaks. Infectious complications can be minimized by delaying diagnostic antegrade nephrostograms until an existing infection has cleared. Hemorrhage and urine leaks are less avoidable but can be minimized by careful attention to technique. Three cases of traumatic pseudoaneurysm with prolonged and recurrent bleeding have been reported. These were successfully treated via trans-catheter embolotherapy.<sup>11</sup> The overall incidence is less than 1%.

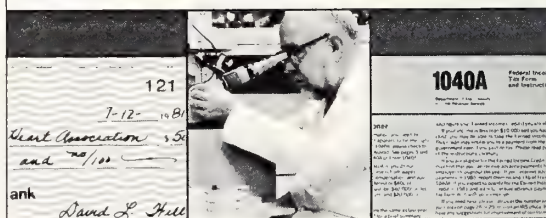
Minor complications occur in 10% to 16% of cases. Hematuria is the most common of these. Generally, it is transient and clears completely in 1-2 days. Persistence beyond this time should prompt evaluation for another cause of bleeding.

Small perinephric hematomas commonly occur, (8% to 10%) but are rarely a cause for concern. Asymptomatic bacteriuria is almost always present. Additional rare but reported complications include pelvocalyceal system rupture, pneumothorax, and catheter placement in small or large bowel. All have occurred without clinically significant sequelae.

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

## DECEMBER

### Cancer

#### Management of Head and Neck Cancer

**For:** MD's, Oncologists. **Lecture,** Dec. 9, Chicago. **Sponsor:** Illinois Comprehensive Cancer Center, 36 S. Wabash Ave., Suite 700, Chicago 60603. **Cosponsor:** U of Chicago Cancer Research Center. **Fee:** \$50. **Reg. limit:** 150. **Credit:** Category 1, 6 hours. **Contact:** Margaret Stewart, BSN. **Phone:** 312/346-9813.

### Internal Medicine

#### Lake County Medical Surgical Seminar

**For:** MD's. **Seminar,** 8:00 a.m., Dec. 15, Waukegan. **Sponsor:** St. Therese Hospital, 2615 Washington, Waukegan 60085. **Reg. deadline:** 12/13. **Fee:** \$5. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** R. M. Adelman, MD. **Phone:** 312/578-2555.

### Neurology

#### Neurology for the Non-Neurologist

**For:** Internists, FP's, Psychiatrists. **Course,** Dec. 8-10, Chicago. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, CME, 600 S. Paulina, Chicago 60612. **Reg. deadline:** none. **Fee:** \$350. **Reg. limit:** none. **Credit:** Category 1, 20 hours. **Contact:** Barbara Trejo. **Phone:** 312/942-7095.

### OB/GYN

#### Advanced Colposcopy

**For:** Ob/Gyn. **Course,** December 3-4, Chicago. **Sponsor:** Northwestern University Medical School, CME, 301 E. Chicago Ave., Chicago 60611. **Reg. fee:** \$290. **Credit:** Category 1, 12 hours. **Contact:** Paula Puntunney. **Phone:** 312/649-8533.

### Pathology

#### Male Infertility

**For:** Pathologists. **Lecture,** Dec. 13, 7:30 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Marshall Short, MD, Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, MD. **Phone:** 312/626-4300 x 383.

### Pathology

#### Liver & GI Clinico-Pathologic Conference

**For:** MD's. **Lecture,** Dec. 27, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

### Rheumatology

#### Fibrinolysis

**For:** MD's. **Lecture,** 9:00 a.m., Dec. 6, North Chicago. **Speaker:** Nicholas Joyce-Clarke, MD. **Sponsor:** Dept. of Rheumatology, UHS/CMS, 3333 Green Bay Rd., North Chicago. **Fee:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

### Rheumatology

#### Cyclic Nucleotides

**For:** MD's. **Lecture,** 9:00 a.m., Dec. 20, North Chicago. **Speaker:** Ira Fenton, DO. **Sponsor:** Dept. of Rheumatology, UHS/CMS, 3333 Green Bay Rd., North Chicago. **Fee:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

#### Male Infertility, Infertility and Contraception

**For:** FP's, Internists, Urologists. **Lecture,** Dec. 6, Chicago. **Speaker:** Thomas John, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$250. **Reg. limit:** 85. **Credit:** Category 1, 19 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## JANUARY

### Family Medicine

#### Results of Recent Advances in Medicine

**For:** Pediatricians, Internists, FP's. **Symposium,** Jan. 17-19, Telemark Lodge, Cable, WI. **Sponsor:** U of WI, CME, 610 Walnut St., Madison, WI 53706. **Fee:** \$235. **Credit:** Category 1, 14 hours; AAFP Prescribed, 14 hours. **Contact:** Ann Bailey. **Phone:** 608/263-2854.

### Headache

#### Diagnosis & Treatment of Headache

**For:** MD's, DO's. **Workshop,** Jan. 13-15, Marriott's Camelback Inn, Scottsdale, AZ. **Sponsor:** American Association for the Study of Headache, 5252 N. Western Ave., Chicago 60625. **Reg. deadline:** 11/10. **Fee:** \$275. **Reg. limit:** 300. **Credit:** Category 1, 15 hours; AAFP Prescribed, 15 hours; AOA, 2-D. **Contact:** Seymour Diamond.

### Internal Medicine

#### The Year in Internal Medicine

**For:** Internists, FP's, GP's. **Lecture,** Jan. 26-29, Chicago. **Sponsor:** Northwestern University Medical School, CME, 301 E. Chicago Ave., Chicago 60611. **Reg. fee:** \$200. **Credit:** Category 1, 20 hours. **Contact:** Paula Puntunney. **Phone:** 312/649-8533.

### Pathology

#### Liver & GI Clinico-Pathologic Conference

**For:** MD's. **Lecture,** Jan. 25, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

### Pathology

#### Biochemical Evaluation of Pancreatic Disease

**For:** Pathologists. **Lecture,** Jan. 10, 7:30 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Marshall Short, MD, Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, MD. **Phone:** 312/626-4300 x 383.

### Pediatrics

#### Chronic Pulmonary Disease in Pediatrics

**For:** Pediatricians. **Symposium,** Jan. 14-15, Chicago. **Sponsor:** Children's Memorial Hospital, Dept. of Clinical Dietetics, 2300 Children's Plaza, Chicago 60614. **Reg. deadline:** 1/7. **Fee:** \$30. **Reg. limit:** 200. **Credit:** Category 1, 8 hours. **Contact:** Roberta Cooper. **Phone:** 312/880-4793 x 4792.

### Surgery

#### Specialty Review in Thoracic Surgery

**For:** General & Cardiothoracic Surgeons. **Lecture,** Jan. 24 (6 days), Chicago. **Speaker:** Sidney Levitsky, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 200. **Credit:** Category 1, 48 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Urology

#### Genitourinary Pathology

**For:** Urologists. **Course,** Jan. 27-30, Airport Marriott, St. Louis, MO. **Sponsor:** American Urological Assn., P. O. Box 25147, Houston, TX 77265. **Reg. deadline:** 1/27. **Fee:** \$230, member; \$260, non-member. **Reg. limit:** 150. **Credit:** Category 1, 16 hours. **Contact:** Alice Henderson. **Phone:** 713/790-6070.

### Urology

#### Urologic Pathology & Radiology

**For:** Urologists. **Lecture,** Jan. 17 (5 days), Chicago. **Speaker:** Thomas John, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## FEBRUARY

### Pathology

#### Liver and GI Clinico-Pathologic Conferences

**For:** MD's. **Lecture,** February 22, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Road, North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

### Medicine for Today

#### 32nd Annual Program Illinois Academy of Family Physicians

#### Spring Sessions February—March, 1983

Credit: 15 hours, AMA Category 1 and AAFP Prescribed. Fee: \$75, members; \$85, non-members.

For further information concerning dates and location nearest you, contact: Illinois Academy of Family Physicians, 1200 Harger Road, Suite 405, Oak Brook, IL 60522, (312) 325-8502.

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**ASSOCIATE DESIRED**—For July 1983-1984, family practitioner to join two family physicians, internist and surgeon in a newly formed group; situated 70 miles west of Chicago in a semi-rural area; family practice oriented hospital with full privileges; equal partnership after 24 months; salary and fringe benefits open to negotiation. Send full vitae to: Irving Frank, M.D., (Director) 954 W. State Street, Sycamore, IL 60178.

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# REPORT

## FOR *Illinois Physicians*

### Mandatory Surgical Program Gaining Acceptance

The mandatory ambulatory surgical program for State of Illinois employees, now in its second year, is gaining acceptance from physicians throughout the state, according to Blue Cross and Blue Shield of Illinois.

Although a sufficient data base has not yet been established, indications are that the program will result in savings to the state's health care program.

The program, which went into effect July 1, 1981, provides that certain procedures are not in benefit unless they are performed in an outpatient setting. Agreement was reached on the procedures included in the mandatory ambulatory surgical program with the surgical community. Only those elective surgical procedures which are considered to be the most common are listed.

Payment will not be made for the listed procedures when they are performed in an in-patient setting, unless medical documentation is provided to support treatment on an in-patient basis that relates to the patient's medical condition and history, i.e. operative report, admitting and discharge summary or any other documentation considered appropriate by the physician. The documentation should accompany the Blue Shield claim form when the claim is submitted for processing.

Just as a reminder, following is a list of the procedures included in the mandatory ambulatory surgical program:

Abdominal paracentesis  
Antrum irrigations  
Arthrocentesis  
Arthrography and arthroscopy  
Aspiration of Douglas's  
cul-de-sac  
Bartholin cyst excision,  
marsupialization or I&D  
Bladder puncture aspiration  
Blepharoplasty, non-cosmetic  
Breast biopsy  
Bronchoscopy with or without  
biopsy  
Cervical biopsies or  
polypectomies  
Circumcision male  
Closed reduction of complete  
dislocations or fractures  
Culdoscopy with or without  
biopsy  
Cyst aspiration  
Cystogram  
Cystoscopy with or without  
retrograde pyelogram  
Digit amputation, revision of  
D&C, diagnostic and  
therapeutic  
Dorsal split of prepuce  
Esophageal dilation  
EUA (examination under  
anesthesia)  
Excision of soft tissue lesions  
(nevus, verrucous,  
epithelioma, scar revision)

Fiberoptic endoscopy with or  
without biopsy  
Foreign body removal of  
unnatural material from  
hand or foot  
Frenulotomy of tongue  
Ganglionectomy  
Gastrosocopy with or without  
biopsy  
Herniorrhaphy (up to age 14)  
Hydrocelectomy  
Hymenectomy  
Hysterosalpingography  
I&D (incision and drainage of  
superficial lesions)  
Injection of joint, tendon or  
ligament  
IUD insertion and removal, if  
anesthesia necessary  
Laceration, suture of skin  
Laparoscopy with or without  
tubal ligation  
Laryngoscopy with or without  
biopsy  
Lipoma removal  
Mammoplasty, non-cosmetic  
Meatotomy  
Minor eyelid procedures  
Minor rectal surgery (not under  
spinal)  
Muscle biopsy  
Myringotomy  
Nasal fracture reduction, open  
and closed

Nasal polypectomy  
Nerve blocks  
Node biopsy (superficial)  
Otoplasty, non-cosmetic  
Otoscocopy with or without  
biopsy  
Pin and screw removals from  
hand or forearm  
Proctosigmoidoscopy with or  
without biopsy  
Skin biopsy  
Skin graft (small)  
Submucous resection of nasal  
septum  
Synovial cyst removal  
Tear duct probing  
Thoracentesis for fluid  
aspiration  
Trigger finger  
Triple upper endoscopy  
Urethral dilation  
Variocelectomy  
Vasectomy  
Vein Sclerosing injection  
Venography



# New HMO to Serve Nine Northern Illinois Counties

HMO, Illinois, Inc., and the Blackhawk Area Independent Practice Association (BAIPA) have formed the first federally qualified Health Maintenance Organization program to serve nine northern Illinois counties, according to an HMO Illinois official.

Skip Housh, Director, said the new HMO program is known as the Blackhawk Health Assurance Plan. It serves Winnebago, Joe Daviess, Boone, Stephenson, Carroll, Whiteside, Lee, DeKalb and Ogle counties.

HMO Illinois is already the state's largest HMO, with 47 facilities in metropolitan Chicago and four in the state area serving over 70,000 members. It is marketed and administered by Blue Cross and Blue Shield of Illinois.

BAIPA is an organization of 480 doctors practicing in the nine counties, representing approximately 70 percent of the active physicians in the area.

Housh said persons who enroll in the new plan will select one of the BAIPA doctors as their primary care physician. If their current family doctor is a member of BAIPA, there is no need to change. The primary care physician coordinates all medical care including consultations with specialists and hospitalization, if necessary.

Like other HMO's, the Blackhawk HAP will offer pre-paid services not ordinarily covered by traditional health insurance programs. These include office visits, immunizations, well-baby care and physical examinations in addition to coverage for care in case of hospitalization.

"When we sought to expand our service area to northern Illinois, we immediately thought of BAIPA. Its network of physicians covers both rural and urban areas, and it has demonstrated an ability to provide quality care efficiently," Housh said.

"We expect this new plan to prove very attractive to employers and employees alike. HMO's have an excellent track record for controlling the cost of health care and for containing the rise in insurance premiums. Employees will find that more health services are covered. Because so many of the area doctors are BAIPA members, the chances are good that employees won't even have to change personal physicians," Housh observed.

The new plan will be marketed to qualifying employee groups through the Blue Cross and Blue Shield Plan's Rockford sales office, at 510 N. Church Street.

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## Enrollment Code Needed on FEP Claims Forms

Changes in FEP benefits make it extremely important that all claims submitted include the enrollment code and birthdate of the patient. The enrollment code appears on the subscriber I.D. card before the individual identification number which begins with an "R" and should precede the I.D. number on the claim form.

It can only be one of the following.

The enrollment code can only be one of the following:

101 — High Option, Self Only

102 — High Option, Family

104 — Low Option, Self Only

105 — Low Option, Family

Claims received without the above information will be delayed until the information is obtained.

---

## National HMO Network Created For United Airlines Employees

CHICAGO—Blue Cross and Blue Shield of Illinois will be responsible for a new system making HMO health care services available to United Airlines employees throughout the United States.

The system was established by Blue Cross and Blue Shield organizations through the formation of a national network of 24 HMOs in 18 cities. The 15-state network stretches from New York to Los Angeles, and Hawaii.

The Illinois Plan initiated development of the HMO network with United Airlines headquartered in the Chicago area, and teamed with the Blue Cross and Blue Shield Association in its formation. Management of the network and the coordination of membership information among the various Plans involved will be handled by the Illinois Plan through its affiliated health maintenance organization, HMO Illinois, Inc.

More than 30,000 United Airlines employees are eligible to sign up for the HMO program, with 3,000 located in Chicago-area installations.

"Blue Cross and Blue Shield of Illinois is delighted to be able to offer United Airlines employees the first multi-state HMO network in the Blue Cross and Blue Shield system," said S. Martin Hickman, president of the Illinois Plan.

Bernard S. Tresnowski, president of the Association, the coordinating agency for the nation's 104 Blue Cross and Blue Shield Plans, said "we are committed to the development of the HMOs as part of our cost containment program and as a practical alternative in health care delivery.

"The United Airlines HMO network meets this commitment and provides us with an opportunity to broaden our involvement with HMOs while initiating a new approach in delivering health care," Tresnowski added. "Development of HMO networks is an important part of our national accounts program."

# Medicaid-Medicare-Champus Report

## Emergency Room Visits, Immunization And CT Are Given New Focus

**EMERGENCY ROOM VISITS**—ISMS staff has been receiving inquiries from physicians regarding the revised guidelines for billing IDPA emergency room services.

When IDPA originally proposed to develop a Basic Health Protection Plan for emergency medical services, the Department sought to limit reimbursement to hospitals and physicians to *only* those procedures which IDPA considered to be true emergencies.

After a series of negotiations between the Department of Public Aid, ISMS and the American College of Emergency Room Physicians, Illinois Chapter, a revised set of guidelines was developed.

The current guidelines are effective for emergency room services performed on or after August 1, 1982. Under these guidelines, both the physician and the hospital will be reimbursed for all services performed in the emergency room.

The Department will now record data on recipients whom IDPA identifies as inappropriately utilizing the emergency room for non-emergency visits. The decision on what constitutes an emergency visit rests solely with the physician. Those recipients found to have inappropriate patterns of emergency room utilization will be counseled by IDPA personnel in order to direct them to the appropriate setting to receive health care services.

For IDPA data collection purposes the following conditions will verify that the services rendered in a hospital emergency room were necessary for treating a recipient in the emergency room:

- (1) obstetrical crisis/labor
- (2) acute trauma
- (3) reparative or reconstructive surgical procedures
- (4) hemorrhage or threat of hemorrhage
- (5) serious infection
- (6) severe pain
- (7) shock or impending shock
- (8) decompensated vital functions or threat to vital functions such as sensorium, respirative, circulation, excretion and sensory organ.
- (9) congenital defects or abnormalities in a newborn
- (10) any condition the management of which requires prompt diagnosis
- (11) any condition which causes severe pain or that may result in disability or death if not promptly diagnosed and treated
- (12) child/adult abuse
- (13) sexual assault

The hospital bills IDPA for emergency room services by indicating the specific nature of the medical emergency on the hospital MMIS claim form. If, in the physician's judgment, the visit is not an emergency, a non-emergency should be indicated on the hospital billing form. The Department will use this information to target those recipients who may be inappropriately utilizing the hospital emergency room for routine health care.

In addition, the Department has prepared a similar listing that is to be given to IDPA recipients who receive medical treatment in the emergency room. The Department expects that by informing the recipient of the proper use of the emergency room, the high level of inappropriate use will be curtailed through recipient education in choice of appropriate settings for receiving health care services.

**IMMUNIZATIONS**—Recently, physicians have received conflicting information regarding the subject of immunizations. Previously, the Department of Public Health supplied the serum at no charge to physicians for their use in immunizing IDPA and other patients. However, reductions in funding to this IDPH program have prevented the Department from continuing this practice.

After September 1, 1982, the Illinois Department of Public Aid began providing reimbursement to physicians for administering immunization services to IDPA recipients. The immunizations covered by IDPA are as follows:

CPT-IV	IMMUNIZATIONS
90720	Diphtheria, Pertussis, Tetanus (DPT)
90720	oral Poliomyelitis immunizations
90720	Diphtheria, Tetanus
90721	single virus vaccine - Measles, Mumps, Rubella (MMR)
90722	double virus vaccine (MMR)
90723	triple virus vaccine (MMR)



Physicians who administer these immunizations for children should now bill the Department of Public Aid using the *Medichek claim form* (claim form #PH0600). Physicians who bill IDPA using the Medichek form for immunizing IDPA patients will receive the maximum allowable reimbursement for a Medichek visit.

Physicians who bill IDPA on the MMIS form 2360 for immunizations will receive reimbursement based upon the Department's maximum allowable cost for dispensed drug products, *i.e.*, cost plus 20 percent and a fee for administering the immunization.

Physicians should be aware that the reimbursement for the Medichek visit was increased by the Department to \$15.00 effective in April 1981. The reimbursement for the Medichek visit will normally exceed the reimbursement for reporting immunization services on the MMIS claim form.

**TAX EQUITY ACT**—The Tax Equity and Fiscal Responsibility Act of 1982 contains several provisions which may affect radiologists and pathologists. The Act requires that all Medicare radiology and pathology services provided subsequent to October 1, 1982 be subject to Medicare-Part B reimbursement requirements. This provision applies to those radiologists and pathologists who had previously signed an agreement with EDS-F to accept all Medicare assignments for services to Medicare clients. The Omnibus Reconciliation Act of 1980 provided that radiologists and pathologists, who agreed to accept all Medicare assignments, would be reimbursed at 100% of the Medicare determined allowable charges.

Conversely, under the Tax Equity Act of 1982, radiology and pathology services now will be subject to the Medicare-Part B deductible and existing Medicare reimbursement formulas. The Part B deductible is currently \$75.00. In addition, reimbursement for these services now will be made at 80% of the reasonable charges as determined by the Medicare carrier. Physicians who accept assignment may submit a bill to the patient or another third party carrier to obtain the 20% co-insurance.

Physicians who do not accept Medicare assignment may bill the patient directly for the full amount of their charges.

**CT SCANNING**—Recently, Illinois physicians have inquired about the CAT scanning policies of third party payors.

Under the Medicare regulations computerized tomography is reimbursable for all reasonable medical indications that necessitate administering a head or body scan.

Medicare guidelines indicate reimbursement will be made when: (a) the scan is reasonable and necessary for the individual patient and (b) the scan is performed on CT scanning equipment that is properly approved and licensed.

The determination of what is reasonable and necessary is based on the use of the CT scan as it relates to the patient's symptoms and diagnosis. The Illinois Medicare carrier does not require that other diagnostic radiology tests be performed prior to use of a CT scan. However, physicians who bill for these services should document the medical necessity for performing a scan and append to the Medicare claim form information which will differentiate a CT scan from other radiological services.

EDS-F, the Medicare Part B carrier, will provide reimbursement for CT scans performed in an inpatient, outpatient or ambulatory setting as long as these criteria are met.

Additionally, Wisconsin Physician Service, the fiscal intermediary for CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) has issued revised guidelines for computerized axial tomography. The CHAMPUS program, unlike Medicare and Medicaid, is subject to rules and regulations promulgated by the Department of Defense.

WPS will reimburse physicians who perform CT scans, either on an inpatient, outpatient or ambulatory basis, provided those services meet the following criteria:

- The patient must be referred to the radiologist who performs the diagnostic procedure.
- The CT scanning procedure must be medically appropriate for the patient based on the preliminary diagnosis.
- The physician must indicate that other non-invasive radiology procedures have been performed or are not medically appropriate for the patient's condition.
- The CT scanning equipment is licensed in accordance with state licensing requirements.
- The CT scanning equipment is used under the general supervision of a physician.
- The results of the diagnostic procedure must be interpreted by a physician.

Physicians who bill Wisconsin Physician Service for CT scanning procedures should include sufficient documentation with a claim to indicate the preliminary diagnosis and symptoms, the name of the referring physician and the name of the physician who interprets the CT scan (if other than the attending physician).

The Illinois Department of Public Aid will also provide reimbursement for CT scanning procedures. IDPA will reimburse for CT head scans that are performed on an inpatient/outpatient basis or in a physician's office. However, IDPA will only provide reimbursement for body scans that are performed in a hospital setting (inpatient or outpatient). For IDPA reimbursement purposes the CT scan must be performed on scanning equipment properly licensed according to Illinois licensing requirements. The physician's diagnosis must indicate the medical necessity for a CT scan and the procedure must be performed under the direct supervision of a physician.

IDPA will reimburse the physician for his interpretation of body scans *only* if the hospital does not report its costs as an all inclusive charge.

# EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

*This patient is a sixty-nine year old retired policeman who was in good health until the day of admission. While working in the garden, he suddenly developed dizziness, diaphoresis and left precordial pain that radiated to his left arm. He became dyspneic. The pain lasted twenty minutes. He was admitted to rule out a myocardial infarction. Serum enzymes showed a slight elevation of the creatine kinase (CPK) with a trace of MB band while the SGOT and LDH enzymes remained normal. His physical examination was normal except for an atrial gallop on cardiac examination and a blood pressure of 150/70mmHg. This twelve lead ECG was taken.*



## Questions:

### 1. The ECG shows:

- A. Marked Q-T interval prolongation.
- B. Symmetrical, deep T wave inversion.
- C. ST segment depression.
- D. Sinus bradycardia, rate of fifty beats per minute.
- E. All of the above.

### 2. This ECG is compatible with the following diagnosis/diagnoses.

- A. Acute coronary insufficiency.
- B. Acute subendocardial infarction.
- C. Central nervous system disease, e.g. a subarachnoid hemorrhage.
- D. Marked electrolyte imbalance.
- E. All of the above.

(Continued on page 504)



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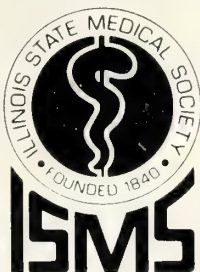
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## ***Phenylbutazone Associated Glomerulonephritis***

# **Glomerulonephritis and Fever**

BY BRUCE M. ROTHSCHILD, M.D., F.A.C.P./CHICAGO

*Medical treatment of hematologic problems carries the liability of a double-edged sword. Nephritis, hepatitis and agranulocytosis are well recognized complications of therapy with phenylbutazone. A case of glomerulonephritis secondary to phenylbutazone is documented.*

The toxicity of cinchophen and aminopyrine, which led to their clinical abandonment, is legendary. Close monitoring of the patient is required with drugs such as corticosteroids, gold, and phenylbutazone. Mauer<sup>1</sup> in 1955 summarized,

from among 3,934 patients, toxic reactions observed with phenylbutazone. There were 1,543 reactions in 1199 patients, of which 14 were listed as renal complications. Belart<sup>2</sup> and Engleman, *et al.*<sup>3</sup> described massive hematuria in three patients. Bruck, *et al.*<sup>4</sup> described degeneration of the convoluted tubules in a patient who developed hematuria and oliguria, after receiving 600mg per day for 28 days, and went on to succumb to renal failure. Lipsett and Goldman<sup>5</sup> described a similar patient. Bowers<sup>6</sup> reported a patient who developed obstructive uric acid nephropathy with hematuria secondary to the uricosuric effect of phenylbutazone. The only other previously reported renal complication of phenylbutazone was salt retention. The presentation of a patient with glomer-

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**BRUCE M. ROTHSCHILD, M.D., F.A.C.P.**, is director of the division of rheumatology, Chicago Medical School and chief, section of rheumatology, Veterans Administration Medical Center, North Chicago. A board certified internist and rheumatologist, Dr. Rothschild's professional affiliations include the American Society of Pharmacology and Therapeutics and the American Association for the Advancement of Science.



ulonephritis and fever, with no apparent etiology save phenylbutazone, provoked this report.

### Case Report

A 54-year old white male was in excellent health until three weeks prior to admission when he had been put on a three week course of phenylbutazone for bursitis of his right shoulder. Three days prior to admission, he complained of fever, chills, and diaphoresis. On the day of admission, his urine became "coke colored" and foamy.

He denied dysuria, nocturia, frequency, dyspnea, hemoptysis, change in bowel habits, change in stool color, chest or abdominal pain, food intolerance, bleeding, neck stiffness, headache, syncope, change in vision, arthritis, malaise, sore throat, exposure to tuberculosis or hepatitis, drug allergy history, rheumatic fever, scarlet fever, photosensitivity, rash, alopecia, Raynaud's phenomena, dysphagia, sinusitis or dental extractions.

Physical examination revealed a middle-aged robust white male in no acute distress. Temperature was 39.2, pulse 108, respiration rate 18, and blood pressure 120/84. There was no evidence of alopecia, skin rash, jaundice, mucosal erosion, clubbing, conjunctival injection or fundic abnormalities. Lungs were clear to percussion and auscultation and heart sounds were normal. The abdomen was non-tender with normal bowel sounds and neither organomegaly nor masses. Costovertebral angle tenderness was not elicitable. There was no neurologic deficit nor was there any sign of arthritis or bursitis. Genitalia were unremarkable, as was rectal examination.

Initial laboratory data revealed a hemoglobin 13.7, hematocrit 40, white blood cell count 5500 with 64 polymorphonuclear leukocytes, 19 bands, and 17 lymphocytes. Random blood sugar was 130, BUN 16, Na 136, Cl 103, K 3.9, and CO<sub>2</sub> 25.

Urine was indeed "coke colored," foamy with a specific gravity of 1.036 with 1+ urobilinogen and 2+ protein. Red cell cast, granular casts, white cell casts, pigmented casts and numerous red cells were seen on microscopic examination. Sedimentation rate (Westergren) was 90, total protein 3.8, calcium 9.0, phosphorus, 3.0, uric acid 4.3, creatinine 1.1, alkaline phosphatase 75, SGPT 36, bilirubin 0.7 total, 0.3 direct, amylase 46, complement 88 (all normal). The LDH 260 was slightly above the normal upper limit of 224 and the SGOT was 51, slightly above the upper normal limit of 40. Prothrombin time, partial thromboplastin time, cold agglutinins, heterophile, ASO titer, VDRL, ANA, rheumatoid factor, Coombs, EKG, blood cultures, and PPD

intermediate strength were all negative or normal. Viral titers showed no rise and no viruses isolated from blood or urine. The phenylbutazone was stopped on admission and the patient defervesced over four days and the urine sediment returned to normal. The patient was not re-challenged.

### Discussion

Jaffe<sup>7</sup> described glomerulonephritis with penicillamine and Schrier<sup>8</sup> described it with penicillin. The case reported implies its development with phenylbutazone. Mauer<sup>1</sup> reported on the high incidence of toxic reactions noted with phenylbutazone. The patient's presentation with "coke colored," foamy urine suggested initially the diagnosis of hepatitis, a reported toxic effect of phenylbutazone.<sup>3</sup> Previous instances of hematuria associated with phenylbutazone were not associated with cellular casts. Greenstone, *et al.*,<sup>9</sup> reported one case of nephrotic syndrome in a patient receiving phenylbutazone. They did note foot process fusion and electron dense deposits. The present case documents glomerulonephritis associated with phenylbutazone presenting with a "telescoped urine." The possibility of deleterious effects of phenylbutazone on the kidney does not seem to have been publicized adequately. This case illustrates a further potential toxicity of this drug. Although this may represent a rare reaction, it serves to emphasize the point of weighing potential risk versus potential benefit. It may be useful to use the lowest effective dose of the least toxic (potentially) agent. Phenylbutazone is probably one of the most potentially toxic of the currently available non-steroidal, anti-inflammatory drugs. ◀

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# Sexual Assault: Collection of Evidence

BY PEDRO A. POMA, M.D./MELROSE PARK

*Despite increased understanding of the ordeal of sexual assault victims, the judicial system may not accomplish its role without adequate "evidence" collection. The Vitullo Evidence Collection Kit permits an opportunity for uniform completion of this task by physicians managing rape victims.*

*This paper, while describing the kit, also reviews the simple but necessary process of evidence collection required on alleged sexual assault victims.*

During the last decade, public awareness about sexual assault has dramatically increased. This improvement in understanding is due primarily to the efforts of several voluntary organizations committed to public education to decrease some of the trauma the victims suffer, increase reporting of this crime and improve administration of justice.

Still, rape occurs more often than reported. The FBI has estimated that in this country a rape may occur every minute.<sup>1</sup> Sexual assault is not only an urban problem. It occurs in rural areas and affluent communities. According to legal definition, rape is comprised of penetration, force and lack of consent.

Concerned parents or relatives and interested investigators trying to relieve some of their anxiety or to speed their work, may pressure attending physicians of a rape victim in order to learn what "really happened." Rape is a crime, not a medical condition; the courts will provide this "diagnosis." The courts will decide whether or not consent was provided. Physicians and other members of the health team in attendance must avoid the temptation of trying to establish whether rape occurred.

Any person can easily recognize that the threat of using force or an assailant with a weapon, will not leave indwelling physical marks on the victim;

that there are other circumstances in which a person is not able to freely consent and that agreements made under duress do not constitute consent. It is important to keep in mind that people react differently to specific types of stress. The physical and emotional condition of the patient may have no relation to what really happened to her.

Management of the sexual assault victim requires a triple approach (Table 1). Physicians feel very comfortable dealing with most aspects. Even if one may not have treated a sexually-abused person before, the general guidelines resemble the management in other diagnoses. However, this attitude may sometimes create new problems, because evaluation of a sexual assault victim requires precise steps. Also, despite today's legal climate, physicians are often concerned about the possible time loss from their practices should it become necessary to participate in the strange world of court proceedings.

The purpose of this communication is to describe an improved version of the *Evidence Collection Kit*, which standardizes and facilitates evidence collection and maintenance of the legal record, and protects the chain of evidence—minimal requirements needed for the courts to prosecute and sentence an assailant.

## Collection of Evidence

Figure I illustrates 1979 Chicago statistics. The ratio of cases known to the police, cases prosecuted, and number of assailants sentenced is lower for rape than for any other violent crime. Considering only actual cases, in 1979 in Chicago 48.7% of those known to the police were prosecuted and only 16.9% of the assailants were sentenced (34.7% of those prosecuted).

The low percentage of sentences is not necessarily associated with the performance of the police, investigators, prosecutors, or the number of

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**Pedro A. Poma, M.D.** is a board certified obstetrician and gynecologist affiliated with Foster G. McGaw, Gottlieb Memorial, Mount Sinai and Westlake Community hospitals in the Chicago area. He is president and former secretary of the Chicago Medical Society West Side Branch, and former chairman of the ISMS Task Force on New Health Practitioners. Dr. Poma has served as both director of OBGYN Education and vice chairman of the Department of OBGYN at the Mount Sinai Hospital Medical Center. A trustee of the Chicago Medical Society, he is assistant secretary for the U.S. Section of the International College of Surgeons.



**Table 1.**  
**Sexual Assault Management**

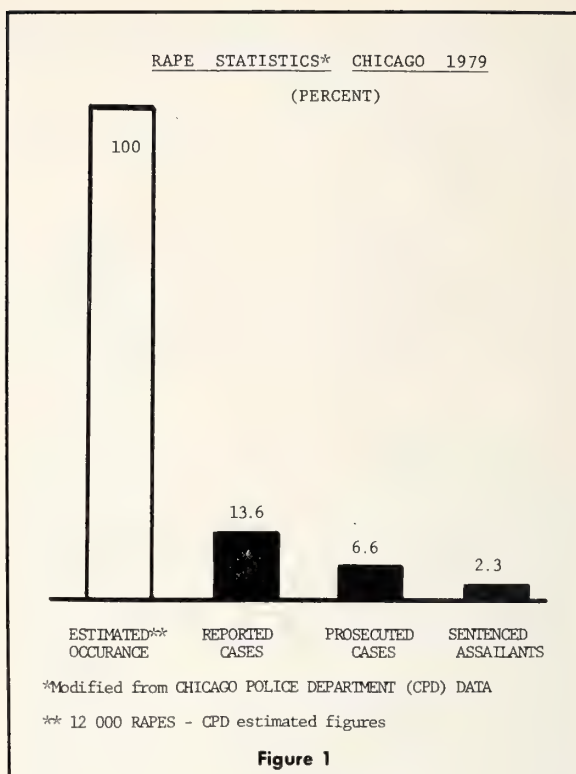
1. Medical:	Evaluation of Injuries, Rx Prophylaxis of VD, Pregnancy
2. Psychological:	Alleviating Stress Management Acute Episode
3. Legal:	Collection Legal Evidence Maintenance Legal Record Protection of Chain of Evidence Follow-Up

victims who become too discouraged to continue with the prosecution of their assailants; nor is it probably caused by the good qualities of the defense attorneys. Although many factors may contribute to the determination made by the courts, if there is no acceptable evidence, there is no case. The resulting situation will be emotionally draining and frustrating for all persons involved and justice will not be served. Obviously, good evidence will also protect the innocent from wrong accusations.

Logistics and the legal requirements involved in maintaining the chain of evidence for courtroom use make evidence collection by private physicians impractical at this time. For these reasons, victims are advised to go to hospital emergency rooms (ER) for treatment after assault. Illinois PA 79-564 orders minimal requirements for the management of sexual assault victims in ER throughout the state. Hospitals in Illinois are required to report felony crimes (such as rape) to the police. Women who do not wish to get involved in a police investigation may be reluctant to seek appropriate medical assistance from ER for this reason. The rape victim should be advised that cooperation or non-cooperation with the police is always her prerogative.

The consent implied by her presence in the ER does not suffice for the collection of specimens that could be used as evidence in court. In order to release the information obtained to the authorities, there is a need for specific consent. Evidence should be collected even if she currently is unwilling to report her assault, to provide for the event that she changes her mind. It must be clearly stated that no information will be given to anyone without her approval. Whether or not she is willing to report should offer no reason to doubt her history nor should it be reason to delay or withhold appropriate management.

Sexual assaults are emergencies. These patients need expert medical care if they are to survive



this trauma with minimal permanent psychological sequelae. Physicians are viewed by most people as advocates and this may facilitate the rapport. But the emergency room cannot provide continuity of care due to the high number of physicians and nurses required to staff shifts and the great variety of cases which they must treat. Although most ER personnel recognize the ordeal of sexual assaulted victims, variations in treating these patients arise because of differences in training and personalities of the persons involved. These variations are appropriate and expected in the practice of the art of medicine but, when managing sexual assault victims, variations may prove disappointing in court.

### The Evidence Kit

In order to facilitate uniformity, familiarity and completeness—not only for the physician and other members of the health team, but also for the police, investigators, evidence laboratory technicians, and the whole judicial system—an evidence collection kit was developed. This kit, with its instructions and forms, was developed by the Citizens Committee for Victim Assistance in cooperation with the now-retired Chicago Police Criminalistics Sergeant Louis Vitullo. This set has been used in Chicago hospitals since September, 1978.

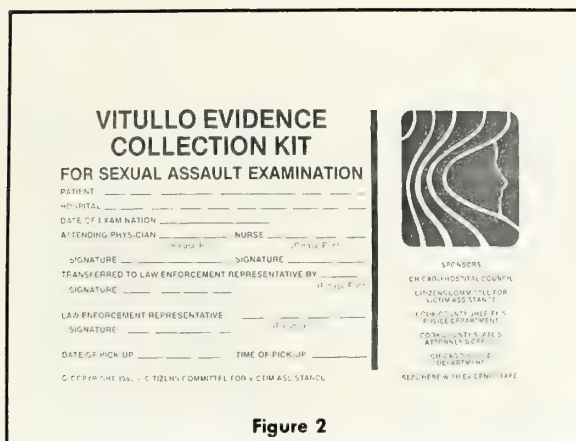


Figure 2

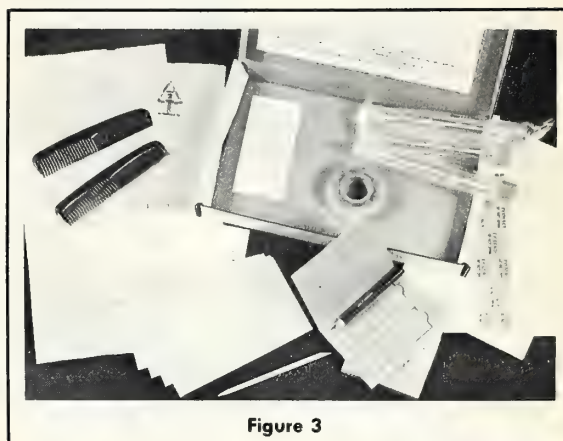


Figure 3

In 1980, a new compact version of the kit was distributed. Storage of the older version had proven difficult, especially for crime laboratories required by law to keep evidence until statutes of limitations run out. (During the first seven months of 1980, more than 1300 kits were delivered to the Chicago Crime Laboratory.<sup>3</sup>)

This new, cardboard version (Figure 2), measures 27cm×16cm×3cm. The information requested on the cover is self-explanatory. All spaces must be filled after the victim's examination and collection of evidence has been completed and before the kit is sealed with the special enclosed red "evidence tape."

On the inside cover of the open kit (Figure 3), a "procedure check list," is noted. By following the list, the procedure becomes organized and valuable legal evidence will not be lost.

Just before the exam, remove the patient's clothing over a white cloth or sheet of paper. Collect any debris that fall from the clothing and place in an envelope. Small items are placed in small paper bags. For the larger items, larger-hospital-provided bags are required. In order to assist evidence technicians, clothes should not be shaken and any existing holes in the garments should not be cut. (Each item should be placed in a separate bag.) With the patient in gynecological position and with the speculum in place, a gonorrhea culture should be taken.

With the cotton-swab of the first tube, take a vaginal smear (frosted slide, identification with pencil) and allow it to dry. Aspirate vaginal secretions and place them in the first tube with the cotton swab. Irrigate with distilled water before aspiration, if necessary.

Using the cotton swab from the second tube take rectal smear, moisten it with distilled water

and allow it to dry. Swab the rectal area again, and place the swab in the tube.

Take an oral smear using cotton swab from the third tube, allow it to dry. Swab again the oral cavity and place the swab back into the tube.

Using the comb provided collect head and pubic hair samples on a white sheet of paper. Place samples in separate envelopes: 5-10 hairs are needed. When indicated, collect finger nail scrapings with the orange stick. Place scrapings separately in right and left hand envelopes.

It is most important to place every specimen with adequate identification in an appropriate container. The identification is composed of the origin or type of specimen, patient's name, name of the physician and nurse, date and time of collection. Sealing should prevent spillage of liquid contents or contamination of specimens. Placing tape around glass containers will prevent breakage during transport. Slides should not be fixed or stained. Identification should be written with pencil. Other tests, such as a sensitive pregnancy test, and supplies which are not used, should not be included in the kit before sealing.

There is a need for additional material not included with the kit (Figure 4): a white sheet of paper or cloth to collect the evidence present in the patient's clothes; vacutainer tubes for blood type when required by local states attorney's office, or for RPR determinations (when blood samples are included the kit should be stored in the refrigerator); distilled water for vaginal irrigation (normal saline forms crystals after drying, these crystals interfere with the laboratory evaluation); aspiration pipettes, additional paper bags and other material such as culture media for gonorrhea and other tests indicated.

Orifice specimens are collected according to the type of assault: in a previous study 4% of the





Figure 4

victims reported rectal and oral penetration.<sup>4</sup> When in doubt about the type of assault, specimens from the 3 orifices should be obtained.

The kit also provides an instruction sheet, a medical report form, a patient information sheet, and an "authorization for release of information and evidence to law enforcement agency" form. (The latter 3 are on self-carbon paper.)

*The medical report form* is a brief checklist, containing the minimal pertinent information required to attend the patient's needs. The original and the copy are kept in the hospital files. The patient information sheet explains the tests and the procedures done, advises the patient about medications given, appointments for follow-up and telephone numbers of other agencies for further assistance and counseling. The original is given to the patient and a copy is retained with the hospital records. *The release of information and evidence form*, in a check list fashion, identifies the items the patient agrees to release to law enforcement agencies, including the medical information, X-rays, slides, smears, specimens, photographs, and pieces of clothing. The bottom part of this form initiates the chain of evidence by identifying the type of information or evidence, the member of the law enforcement agency receiving the material and who will carry this material to the crime laboratory.

## Comments

Evidence collected in this standardized method has been presented to courts, and it has proven to be of significant influence, according to the jurors.<sup>3</sup> At this writing, 215 hospitals in Illinois are using the Vitullo Kit. Standardization of evidence collection facilitates crime laboratory technicians and investigators' work. They are

receiving more complete material. Therefore cases can be transferred to the prosecutor's offices with better documentation.

Outside Cook County, local regulations require that all natural orifices are tested, the hair samples plucked rather than combed; blood and saliva samples. The blood is collected for one tube with, and another without, anticoagulant; four drops of blood are also placed on the filter paper. The envelope containing filter paper for the saliva test should be given to the patient. After the paper is saturated with saliva she introduces it into the envelope, which is sealed with the scotch tape provided. None but the patient should touch this filter paper. If it becomes necessary to assist the patient, a forceps should be employed to handle it. Outside Cook County, the swabs are not provided with tubes; they are placed in narrow cardboard tubes provided.

Debris, suspicious stains, fibers and hair collected from the white sheet of paper employed when the patient undressed, and from her clothes, may allow the identification of the assailant or the place where the crime occurred. Hair, skin and blood type may assist also in this identification or in the elimination of this possibility for an individual under suspicion.

Obviously, all this evidence collection is not done by the physician; most women will not agree to undress in front of a male physician. But the physician is still considered responsible for adequate evidence collection.

In order to serve justice better, collection of evidence is intimately associated with protection of the chain of evidence, adequate sampling, proper labeling and sealing, and details of the delivery to an adequate person. This is what society expects from physicians assisting these victims of sexual assault. The task of evidence collection is similar to that of technicians working on a crime scene: they follow specific procedures, keep pertinent records, avoid opinions and protect the chain of evidence.

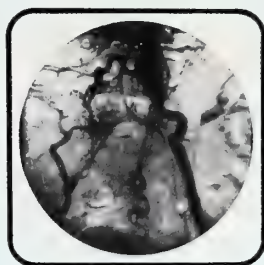
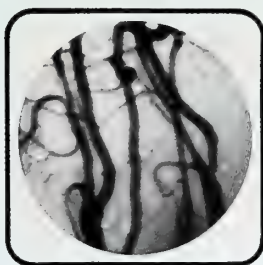
## Acknowledgments

To Rosa E. Herrera, for her continuous support and to the Citizens Committee for Victim Assistance for their technical assistance and cooperation.

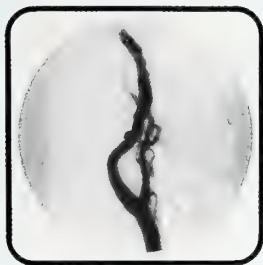
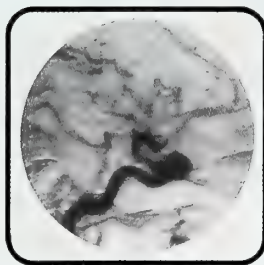
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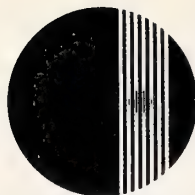
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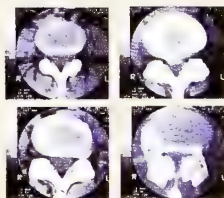


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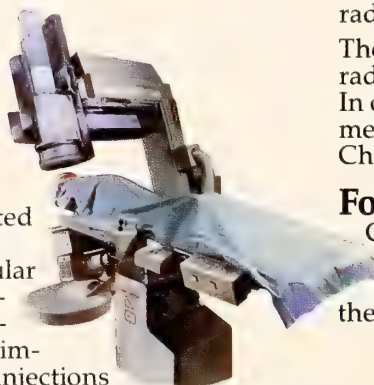
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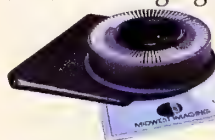
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# Case Reports

## Gastric Carcinoid

BY JOSEPH J. CASEY, M.D. AND JAMES V. APOSTOL, M.D., F.A.C.S./CHICAGO

*Carcinoid tumors rarely occur in the stomach. When present, the correct diagnosis is seldom made before surgery. Symptoms, radiographic and endoscopic findings are not specific unless the patient has the carcinoid syndrome. Therapy depends on the size of the tumor and the presence or absence of metastases.*

The original description of carcinoid tumors was made by Langhans in 1867, although the presence of chromaffin bodies and the designation "carcinoid" was not made until 1907 by Oberndorfer. Gossett and Masson demonstrated in 1914 the affinity of granules in the cytoplasm of the carcinoid cells for silver salts, hence the designation argentaffinoma. Since then, much has been written about carcinoid tumors and their relationship with other high amine content tumors (APUD omas).

Carcinoid tumors have been reported from the gastroesophageal junction to the rectum. The most frequent sites are the appendix (45%), jejunioileum (28%), and rectum (16%). Carcinoid tumor of the stomach is relatively rare. The first two cases were reported by Askanazy in 1923. A total of 93 cases had been reported by 1970.<sup>2</sup> A review of the literature for the last twelve years plus the case presented here brings the total to 99.<sup>3-6</sup>

### Case Report

A 61-year-old black man had upper gastrointestinal endoscopy during investigation for chronic hiccoughs. A 2.0x1.5cm ulcerated mass was described on the greater curve 10cm from the pylorus. A hiatus hernia with mild esophagitis was also noted. Radiologic study of the stomach demonstrated a small but persistent filling defect. The remainder of his history and physical examination was unremarkable. Stools were hemoccult positive. Admission laboratory values were: hemoglobin 9.1, hematocrit 28.9, and WBC=7300. Six weeks earlier, as an outpatient, his hematocrit was 36.4. The patient was taken to the operating room with a preoperative diagnosis of ulcerated leiomyoma of the stomach. A wedge resection was performed which included the mass with generous margins. The mass itself was approximately 1.0x0.5x1.0cm. The remainder of the abdomen was unremarkable. The

liver was normal and there was no adenopathy. Frozen section of the specimen was reported as carcinoid. The margins were free of tumor. The abdomen was closed and the patient recovered uneventfully. Permanent sections confirmed the frozen section diagnosis (Figures 1,2).

### Discussion

Gastric carcinoids are not associated with specific symptoms and the correct preoperative diagnosis is seldom made. In one series of 79 cases, 30 were incidental autopsy findings while only five of the 49 clinical cases had the carcinoid syndrome.<sup>7</sup> The remainder had symptoms of epigastric abdominal pain which was thought to be caused by either gastric cancer or peptic ulceration.

Radiographic findings are variable. Pochaczewsky and Sherman reported that contrast studies of the stomach are usually indicative of some type of neoplasm, most often considered to be a polyp or gastric carcinoma. The majority presented are sharply circumscribed, round, or polypoid filling defects covered with a smooth mucosa.<sup>8</sup>

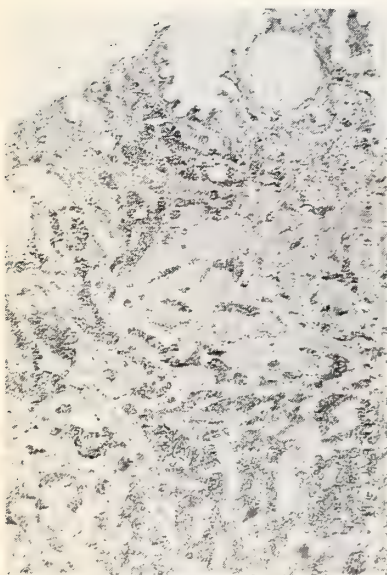
Gastroscopy has also failed to yield the correct diagnosis. Five of the reported patients were subjected to gastroscopy and a lesion was noted in each case. In only one case did the combination of clinical symptoms (carcinoid syndrome), laboratory data (elevated urinary 5 HIAA), gastric contrast studies, and gastros-

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**JAMES V. APOSTOL, M.D.**, is a board certified surgeon affiliated with Northwestern Memorial Hospital in Chicago. An assistant professor of surgery at Northwestern University Medical School, he is a member of the American Cancer Society and a fellow of the American College of Surgeons.

**JOSEPH J. CASEY, M.D.**, is a fifth year resident in general surgery at Northwestern Memorial Hospital in Chicago.





**Figure 1**

**Photomicrograph showing normal gastric mucosa above with underlying carcinoid.**

copy yield the correct preoperative diagnosis.

Grossly a carcinoid tumor usually appears as a single, submucosal nodule superficial to muscular layers of the gastrointestinal tract. They are small, firm, and rubbery in consistency. On cut section, the color is usually a gray-yellow. They may extend into the muscularis layers and may ulcerate with subsequent hemorrhage. The more malignant tumors are larger and may be multiple. The regional lymph nodes are invaded first and metastases may occur in the liver later.

Masson has shown histologically that carcinoid tumors contain cytoplasmic granules that reduce silver ammonium oxide. Such granules are also present in Kultchitsky's cells in the crypts of Lieberkuehn. Gaspar has found by serial sections that the carcinoid tumor arises from the cells of the crypts of Lieberkuehn. The incidence of carcinoid tumor in different locations roughly parallels the frequency with which the Kultchitsky's cells are found.<sup>9</sup>

Carcinoid cells are strikingly uniform and arise from normal epithelium extending into submucosa.

They have an eosinophilic cytoplasm and a centrally placed spherical nucleus. Mitoses are very infrequent. The nests of cells are separated with a dense stroma and are encapsulated by smooth muscle and connective tissue. The capsule is false and offers little resistance to the invasion of the tumor cells. Metastases, when they occur, do so slowly. The characteristics of the cellular morphology do not indicate the degree of malignancy, which is determined by the clinical behavior.<sup>9</sup>

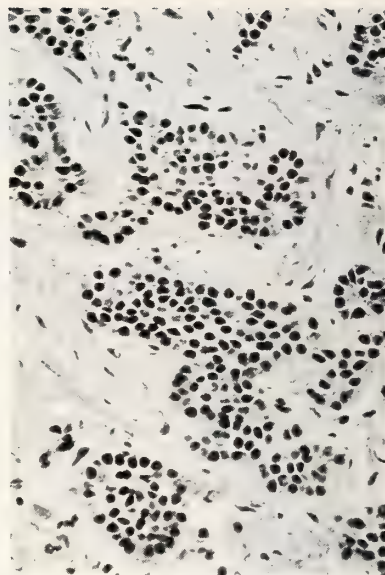
The treatment for gastric carcinoid is surgical. For small tumors, local resection is adequate. Larger tumors, however, may require gastric resection. Because most carcinoids are slow growing, aggressive resection of bulk disease (as with other hormonally active tumors) may improve symptoms and survival. In patients with unresectable, metastatic, or recurrent carcinoid, two approaches are available. The first is antihormonal therapy to relieve symptoms caused by the biologically active mediators. The second is cytotoxic chemotherapy aimed at destroying the tumor.<sup>10</sup> Carcinoid is typically radioresistant.

### Summary

A 61-year-old man was found to have a carcinoid of the stomach and was treated by local excision. The stomach is an unusual location for a carcinoid tumor. Symptoms and signs, if any, are nonspecific and include epigastric pain, gastrointestinal bleeding, and anemia. The carcinoid syndrome is not present unless the patient has liver metastasis. Radiographic and endoscopic studies are nonspecific. Small carcinoids may be treated by local excision. Larger tumors require gastric resection and metastasis may be treated by aggressive surgery and/or chemotherapy. ◀

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**Figure 2**

**Higher power of the same section showing typical nests of carcinoid cells.**

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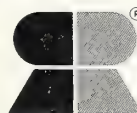
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# IMPAC

## Illinois State Medical Society

### Political Action Committee

55 East Monroe Street

Chicago, Illinois 60603

312/782-1963

Dear Colleague:

The IMPAC Council is pleased to report to you that your political action committee is concluding another successful year on behalf of organized medicine.

Since 1982 was an election year, IMPAC activity was especially vigorous. On November 2, Illinois voters selected a new General Assembly of 59 senators and 118 representatives. In this election, they also chose the state's six executive officials, as well as 22 U.S. congressmen. IMPAC played a role in 184 of these races and in many was a major factor in determining the outcome. Of the candidates supported, 153 were declared elected -- giving IMPAC an 85% success rate.

IMPAC disbursed over \$200,000 to candidates in the General Election, relying on local IMPAC members for advice when making these contributions. This local input is a key dimension to effective political action, for it fashions a physician/legislator relationship that becomes extremely valuable when legislation is considered.

As we approach 1983, we should keep in mind that our electoral activity this past year is only the groundwork for success in the halls of government. In the weeks ahead we must solidify the physician/legislator relationships around the state that will become the cornerstone of our legislative achievements.

IMPAC continues to be a necessary and vital part of organized medicine's program to protect the integrity of medical practice. Your IMPAC Council is grateful to all members who made 1982 a successful year of political action. Without your support it would not have been possible.

As we enter the new year please remember to make your 1983 contribution. Your continued support is the foundation of medicine's future.

Sincerely,



P.F. Mahon, M.D.  
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, & 110.5. (Federal Regulations require this notice.) IMPAC reports are filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois, 62704. Voluntary membership contributions support political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC.

NON PARTISAN

# The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,  
Department of Radiology, Loyola University Stritch School of Medicine

*This month's Viewbox was contributed by Edward Bruno, M.D., department of radiology, Loyola University Medical Center, Maywood.*

*This newborn baby was meconium stained at birth and had an APGAR of 3/5. Following intubation, O<sub>2</sub> was started. A few hours later the baby was still in respiratory distress.*



**Figure 1**  
Chest radiograph shows a tension pneumothorax.



**Figure 2**  
Following insertion of a chest tube a second chest radiograph shows resolution of pneumothorax but an abnormal left lung.

## Your Diagnosis?

- (a) Congenital Lobar Emphysema
- (b) Staphylococcal Pneumonia with Pneumatocele
- (c) Congenital Cystic Adenomatoid Malformation
- (d) Diaphragmatic Hernia
- (e) Intrapulmonary Bronchogenic Cyst

*(Continued on page 506)*



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**The sooner, the better.**

\*Please see following page for Brief Summary of Prescribing Information.





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**Inderal<sup>®</sup>** (propranolol hydrochloride)

BEFORE USING Inderal (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

### CONTRAINDICATIONS

1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

### WARNINGS

**CARDIAC FAILURE:** In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction

**IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE,** in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over

**IN PATIENTS WITH ANGINA PECTORIS,** there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when Inderal is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications

**IN PATIENTS WITH THYROTOXICOSIS,** possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests

**IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME,** several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol

**IN PATIENTS UNDERGOING MAJOR SURGERY,** beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levaterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported

**IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM** (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors

**DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA:** Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks

**USE IN PREGNANCY:** Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose

### PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function

### ADVERSE REACTIONS

**Cardiovascular:** bradycardia, congestive heart failure, intensification of AV block; hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. **Central Nervous System:** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory:** bronchospasm. **Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase lactate dehydrogenase

### HOW SUPPLIED

#### TABLETS

— Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99)

— Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains 20 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99)

— Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains 40 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99)

— Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains 80 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99)

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Store at room temperature (approximately 25° C).

#### INJECTABLE

— Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).

Store at room temperature (approximately 25° C).

**Reference:** 1 Freis, E.D. Hypertension (Suppl. II) 3:230 (Nov.-Dec.) 1981

7997/882

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# Illinois Society, American Association of Medical Assistants

## Guided Study Courses

Physicians have traditionally trained office assistants themselves, and in these days of high turnover the medical assistant who works more than a few years and becomes truly proficient can be an enormous asset. However, most physicians know little about the mechanics of office administration unless they have taken time out from their medical duties for business courses. Moreover, the physician who hires an untrained assistant cannot be certain the person hired will remain after the training period.

The prime purpose of Illinois Society, AAMA, is education of the medical assistant either thru courses in community and junior colleges, private health career and/or vocational schools or continuing education services offered by the organization. The latter include seminars, workshops and articles in our publication, *The Professional Medical Assistant*. Guided study programs are also available to enable medical assistants to study and learn at their own speed and on their own time.

The three courses currently available are: (1)

Anatomy, Terminology and Physiology; (2) The Humanistic Medical Assistant; and (3) Specimen Collection and Preparation. Each course consists of tapes and workbooks which are ordered either thru Illinois Society or AAMA. Other courses are being developed and will be available soon.

All of the above are designed to help the medical assistant, *your* assistant, to become more efficient and effective in your practice. As medical assistants we feel the work we do is more than just a job. It is a career and we hope physicians feel we are important members of their health care team. We truly care about our employers, their patients and the community in which we live.

Information regarding the guided study courses or Illinois Society, AAMA, may be obtained from Janet Binkowski, RN, President, 428 Adams Street, Dolton, IL 60419, or Ruby Jackson, CMA, Chairman, Public Relations Committee, 7337 South Shore Drive, #625, Chicago, IL 60649. ◀



# Special Articles

## Estate Planning

BY STANLEY M. PILLMAN, J.D./CHICAGO

*The following is a general overview of estate planning considerations pertinent to physicians, developed by the ISMS insurance plans representatives. This information will be supplemented by seminars at county medical society meetings in 1983.*

*Readers are encouraged to consult with their individual accountants or attorneys for specific, concrete advice in this area. The following general information piece may not apply to specific cases and should not be regarded as individual counsel.*

In the near future, the ISMS Insurance Plans representatives will be offering seminars on estate planning through the local county medical societies. This article will focus on new developments in estate planning that have come about because of the Economic Recovery Tax Act of 1981 (ERTA). The Federal estate and gift tax changes have received widespread publicity. Some newspaper and magazine articles suggested that the need for estate planning is gone. This is not true. The majority of physicians still need proper planning of their estates.

One of the most significant changes was in the amount of the unified credit. This is the amount of money that may be passed without any estate tax. This credit is available to all estates. The credit is being introduced by a phase-in period between now and 1987. The following shows the

amount of credit available during this phase-in period:

Year of Death	Credit	Exemption Equivalent
1982	\$ 62,000	\$225,000
1983	79,300	275,000
1984	96,300	325,000
1985	121,800	400,000
1986	155,800	500,000
1987	192,800	600,000

After 1986, no taxable estate of less than \$600,000 will be subject to Federal tax. Because the unified credit is phased in over the next four years, there may be some estate tax liability for an estate today that will disappear by 1987.

The maximum estate tax rate has also been reduced from 70% to 50% and it will be phased in over a four year period between now and 1985. By 1985, the maximum estate tax rate will be 50% applied to transfers in excess of \$2,500,000. There is no change in the tax rates for transfers under \$2,500,000.

One other major change was in the area of the marital deduction. The existing law limited the marital deduction to the greater of \$250,000 or 50% of the adjusted gross estate. The new law provides that one spouse can make unlimited gifts or bequests to the surviving spouse without incurring any Federal gift or estate tax liability. This means that any spouse, regardless of the size of his or her estate, can now avoid Federal estate tax by passing all the property to the surviving



**STANLEY M. PILLMAN, J.D., CLU**, is the Estate Planner for the Illinois State Medical Society Insurance Plans. He is a member of the Chicago Estate Planning Council and the Chicago Bar Association Federal Taxation Committee.

spouse outright or to a trust for the spouse which qualifies for the marital deduction. This provision does not in any way eliminate estate taxes but merely transfers the estate tax burden to the surviving spouse's death. For estate planning purposes, a physician should consider the amount of expected earnings on the estate assets between the first and second deaths. If the assets are expected to produce substantial earnings, proper planning might dictate that some tax should be paid at the first death as opposed to the second death, when the estate might be pushed into a higher estate tax bracket.

Many physicians have already established marital deduction trusts under what is commonly known as "A"/"B" Trust Planning. A marital trust under these plans was commonly drafted to limit the marital deduction to \$250,000 or 50% of the adjusted gross estate. It may have also been drafted to contain a provision that defined the marital deduction as the maximum amount available. If documents were executed prior to September 13, 1981, the unlimited marital deduction will not apply. To make it apply, the will or trust should be amended to refer specifically to the unlimited marital deduction.

This does not mean that every estate will want to take advantage of the unlimited marital deduction. Each estate should take advantage of the unified credit then in-force and let the balance of the estate pass under the unlimited marital deduction clause. In other words, proper planning might dictate that the exemption equivalent go into the family trust with the balance of the estate going into the marital trust. This would produce no Federal estate tax at the first death. The amount of tax due at the second death would be the amount in the marital trust that is in excess of the in-force unified credit.

Prior to ERTA, joint tenancies with rights of survivorship between spouses were included in the decedent's gross estate based on the amount of money contributed by the decedent for the property. If a physician had a non-working spouse who did not contribute any money toward purchase of their jointly owned residence, the full value of the residence would be included in the physician's gross estate. Under ERTA, these joint tenancies are treated as one-half owned by each spouse for estate tax purposes. Now one-half the jointly owned residence will be included in each spouse's gross estate. This change could cause more assets to be included in a spouse's estate than was originally contemplated under the old law.

There was also a significant increase in the annual gift tax exclusion for gifts of present interests

from \$3,000 to \$10,000. If the donor's spouse joins in the gift, \$20,000 per donee can be excluded from gift tax each year. There is also an unlimited gift tax exclusion permitted for amounts paid on behalf of a donee directly to an educational organization for tuition and to a health care provider for medical services. This unlimited exclusion is available regardless of the relationship between the donor and donee.

Physicians, are, of course, interested in the profession and the education of new physicians. One means to support Illinois medical students is through the ISMS Educational & Scientific Foundation's Fund for Financial Aid to Medical Students. These types of bequests should be identified specifically in the will.

This article could not attempt to cover all the changes made by the Economic Recovery Tax Act as they relate to estate planning, but sought to discuss major changes and point out that formal estate planning can enable the physician to take full advantage of the provisions.

Estate planning seminars are planned for 1983 through county medical societies. There, the changes will be covered in more detail and questions can be answered. After the seminar, individuals may choose to take advantage of the estate planning service in individual sessions. ◀



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\*Note: Seminars comply with IRS Regulations for deductibility if the primary purpose is business and professional.

# Pulse of the ISMS Auxiliary

*Are You Aware . . .*

## PSST

BY MRS. DON HINDERLITER/ISMSA PRESIDENT

Have you heard about Operation PSST? This stands for Physicians' Spouses Support Themselves.

In my travels as president, one theme has come through loud and clear. Physicians' wives feel there is not a real network support system especially for them. Many times they feel unable to complain about their spouses or air their gripes—even to friends.

How can we, as physicians' spouses, help each other vent some of our feelings?

Does this mean because we get angry at our spouses we don't love them? Of course not.

Certainly, what it does mean, is that physicians' spouses are as human as any other individual in America today. Certainly, what it does mean, is that physicians' spouses need to vent their feelings and frustrations like every other spouse.

A sounding board within the medical spouse community assures the physician's spouse of an arena to release built-up tension. It also reassures her/him that she/he is not alone. If she/he has problems in medical marriage, chances are someone else has also had the same problem and can help. Maybe even just saying it out loud is enough. Just knowing that another spouse cares often helps.

We must begin to support our own. Up to now, we haven't done a real good job.

This is what PSST is all about. Let's make this network of support clearly visible in Illinois.

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## Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

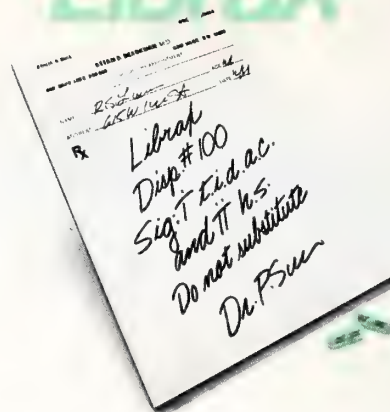
Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style and order: Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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As with all anticholinergics, inhibition of lactation may occur

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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\*WARNING: May be habit forming

**Contraindications:** Hypersensitivity to acetaminophen or codeine.

**Warnings:** Drug Dependence: Codeine can produce drug dependence of the morphine type, and may be abused. Dependence and tolerance may develop upon repeated administration. Prescribe and administer with the same degree of caution appropriate to the use of other oral narcotic medications. Subject to the Federal Controlled Substances Act (Schedule III).

**Precautions:** Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute abdominal conditions:** Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

**Special risk patients:** Administer with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

**Information for Patients:** Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient taking this drug should be cautioned accordingly.

**Drug-Interactions:** Patients receiving other narcotic analgesics, antipsychotics, antianxiety, or other CNS depressants (including alcohol) concomitantly with acetaminophen and codeine may exhibit additive CNS depression due to the codeine component. When such therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with codeine preparations may increase the effect of either the antidepressant or codeine.

The concurrent use of anticholinergics with codeine may produce paralytic ileus.

**Usage in Pregnancy:** Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, acetaminophen and codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

**Nursing Mothers:** It is not known whether the components of this drug are excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when acetaminophen and codeine are administered to a nursing woman.

**Adverse Reactions:** Most frequently: Lightheadedness, dizziness, sedation, shortness of breath, nausea and vomiting. More prominent in ambulatory than in non-ambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Others: Euphoria, dysphoria, constipation and pruritus.

**Dosage and Administration:** Dosage should be adjusted according to severity of pain and response of the patient. However, it should be kept in mind that tolerance to codeine can develop with continued use and that the incidence of untoward effects is dose related. This product is inappropriate even in high doses for severe or intractable pain. Adult doses of codeine higher than 60 mg fail to give commensurate relief of pain but merely prolong analgesia and are associated with an appreciably increased incidence of undesirable side effects. Equivalently high doses in children would have similar effects.

Adults: **Codeine**—15-30 mg (for mild to moderate pain) 60 mg (for moderate to moderately severe pain)

**Acetaminophen**—300-600 mg

Children: **Codeine**—500 mcg/kg

Doses can be repeated up to every 4 hours.

Full directions for use should be consulted prior to administering or prescribing.

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## Obituaries

**\*Brown, Murray C.**, Chicago, died November 8, 1982 at the age of 69. Dr. Brown was a 1938 graduate of the University of Virginia School of Medicine, Charlottesville. An alternate delegate to the ISMS House of Delegates, he was former commissioner, Chicago Department of Health.

Dr. Brown had served as head of the U.S. Public Health Service Occupational Health Department for 30 years before appointment to the city post. A former president of the Chicago Medical Society North Side Branch, he is survived by his wife, Claesa Armstrong, M.D., three children and seven grandchildren.

**Hussey, Hugh H.**, Dallas, Texas, died November 6, 1982 at the age of 71. Dr. Hussey was a 1934 graduate of Georgetown University School of Medicine.

**Rowe, James W.**, Evanston, died September 23, 1982 at the age of 51. Dr. Rowe was a graduate of Northwestern University Medical School.

**\*Rosenberg, Edward F.**, Chicago, died November 1, 1982 at the age of 75. Dr. Rosenberg was a 1934 graduate of Jefferson Medical College of Thomas Jefferson University, Philadelphia.

**\*\*Soter, Spiros D.**, Chicago, died November 5, 1982 at the age of 90. Dr. Soter was a 1922 graduate of Northwestern University Medical School.

**\*\*Thornbloom, Wallace D.**, St. Petersburg, Florida, died November 9, 1982 at the age of 81. Dr. Thornbloom was a 1932 graduate of the University of Nebraska College of Medicine, Omaha.

\*Indicates ISMS member

\*\*Indicates member of the Fifty Year Club



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# Doctor's News

**PHYSICIANS IN THE NEWS**—Three recently elected officers to the American Association of Senior Physicians board of directors are: **Howard C. Burkhead, M.D.**, Evanston, president; **Alexander M. Buchholz, M.D.**, Hazelcrest, chairman; and **Bertram B. Moss, M.D.**, Chicago, vice-chairman.

**Theodore M. Kanellakes**, Joliet, was installed as president of the Illinois Society of Allergy and Clinical Immunology for 1982-83.

**Sherwyn E. Warren, M.D.**, Winnetka, has been elected president of the American Cancer Society, Illinois Division.

**Lee Gladstone, M.D.**, Chicago, recognized for work in the treatment of alcoholism, has been appointed executive director of the Martha Washington Treatment Center in Chicago. Dr. Gladstone is chairman of the ISMS Panel for the Impaired Physician.

**Enrique Redondo, M.D.**, Chicago, was honored physician of the year by the Chicago Boys Club at their Citizen-of-the-Year Dinner held this fall. Dr. Redondo is on staff at St. Francis X. Cabrini and St. Anthony hospitals.

**M. Eugene Tardy, Jr., M.D.**, Chicago, was installed as president of the American Academy of Facial, Plastic and Reconstructive Surgery.

**Hugo H. Muriel, M.D.**, Chicago, received the Torch of Learning Award of the American Friends of the Hebrew University in November.

**James Greene, M.D.**, and **Michael McGirr, M.D.**, both emergency physicians at St. James Hospital, Chicago Heights, have been named fellows of the American College of Emergency Physicians (ACEP).

**LOAN REPAYMENT**—The AMA agrees that action should be taken to secure repayment of loans made under the Health Professions Student Loan Program, according to a recent AMA news release. However, AMA objects to a provision that would cut new loan funds from schools with a better than 5% delinquency rate (accounts more than 30 days overdue are considered delinquent). It recommends that a 60-90 day period determine delinquency and that individual repayment schedules be made according to student ability to pay. In addition, provisions should require schools to join a credit bureau, use collection agents, and file appropriate law suits to recover loans.

**PHYSICIAN SEEKS SPECIALISTS TO FORM TOPIC-ORIENTED SOCIETIES**—Topic oriented specialty groups in (1) cerebrovascular disorders; (2) brain tumors and (3) facial pain are being formed in the Chicago area. Meeting frequency and activity scope are to be determined as the groups evolve. Interested physicians may contact Dr. George Dohrdmann, III; H.B. 405; 950 E. 59th St.; Chicago, IL 60637.

**DIABETIC EYE DISEASE BOOKLET/AUDIO-VISUALS**—The National Society to Prevent Blindness has announced availability of a patient education package entitled, "The Effects of Diabetes on the Eye." The presentation describes the stages of diabetic retinopathy, a disease that blinds some 4,700 diabetics a year. The presentation (color slides with audio cassette) is also available in booklet form. To order, specify booklet (\$4) or slide/cassette (\$60), include a check or money order and write: National Society to Prevent Blindness, 79 Madison Ave., New York, NY 10016.

**DHHS NATIONWIDE TOLL-FREE HOTLINE**—Information regarding fraud, waste and abuse in any of the Department of Health and Human Services programs, including Medicaid and Medicare, can be reported by calling (800) 368-5779 toll-free. Operators in the inspector general's office will answer.



**CONFERENCE ON CARE OF THE TERMINALLY ILL PATIENT**—The AMA and U.S. Public Health Service will co-sponsor a conference on the care of terminally ill patients with severe chronic pain, January 28, in Washington, D.C. The conference will focus on concerns about underprescribing and the use of currently approved drugs to alleviate suffering. Participants will be urged to disseminate pharmacological information to the medical community. Attendance is limited. For further information contact William T. McGivney, Ph.D., Division of Drugs, AMA Headquarters, or call (312) 751-6487.

**AMA MONOGRAPH ON AMBULATORY CENTERS**—“Freestanding Surgical Centers: The Planning and Regulatory Process,” is now available. The publication, based on interviews with physicians and consultants, discusses what can be expected in establishing an ambulatory surgical center. To order, write Order Dept., OP-222, P.O. Box 821, Monroe, WI 53566. Cost is \$9 each for 1-10 copies; \$8.50 each for 11-49 copies and \$7.50 each for more than 50 copies. Handling charges are \$1.50 for orders less than \$10 and \$2.50 for orders of \$10 or more.

**ISMS WORKER'S COMPENSATION PLAN**—The ISMS-sponsored Worker's Compensation Insurance Plan is in the process of issuing total dividends of more than \$64,000 to policyholders. The amount represents a better than 41% return on premiums for the policy year which ended April 1. It is the largest return to members since the program's inception in 1977. This is the sixth consecutive year ISMS has sponsored the program through the Dodson Insurance Group.

Under the ISMS Worker's Compensation Plan a physician earns a return of premium each year when claim costs are low for participating doctors. The lower the cost of claims, the higher the savings.

The program is offered to all ISMS member employers. For more information, contact ISMS Insurance Plans (312) 621-4909.

**CRIB HAZARD WARNING**—The U.S. Consumer Product Safety Commission (CPSC) has warned that “Starlighter” baby cribs can cause a fatal neck entrapment. Consumers were advised to discontinue use of the “Starlighter” cribs in a recent IDPH news release. The “Starlighter” cribs were manufactured by Contemporary Times, Inc., St. Petersburg, Florida, between 1975 and 1978. The company is undergoing a federal bankruptcy proceeding and is not recalling or repurchasing the cribs. For further information call CPSC's toll-free hotline at (800) 638-8326.

**PATHOLOGISTS' ANNUAL SPRING MEETING**—The Annual Spring Meeting of the American Society of Clinical Pathologists and The College of American Pathologists will be held at the Hyatt Regency-Chicago and the Radisson Hotel, Chicago, April 9-14, 1983.

The agenda includes workshops, seminars, and paper and poster sessions in anatomic and clinical pathology. For further information contact Michael Kelleher, ASCP Customer Services, 2100 West Harrison Street, Chicago, IL 60612 or call (312) 738-1336.

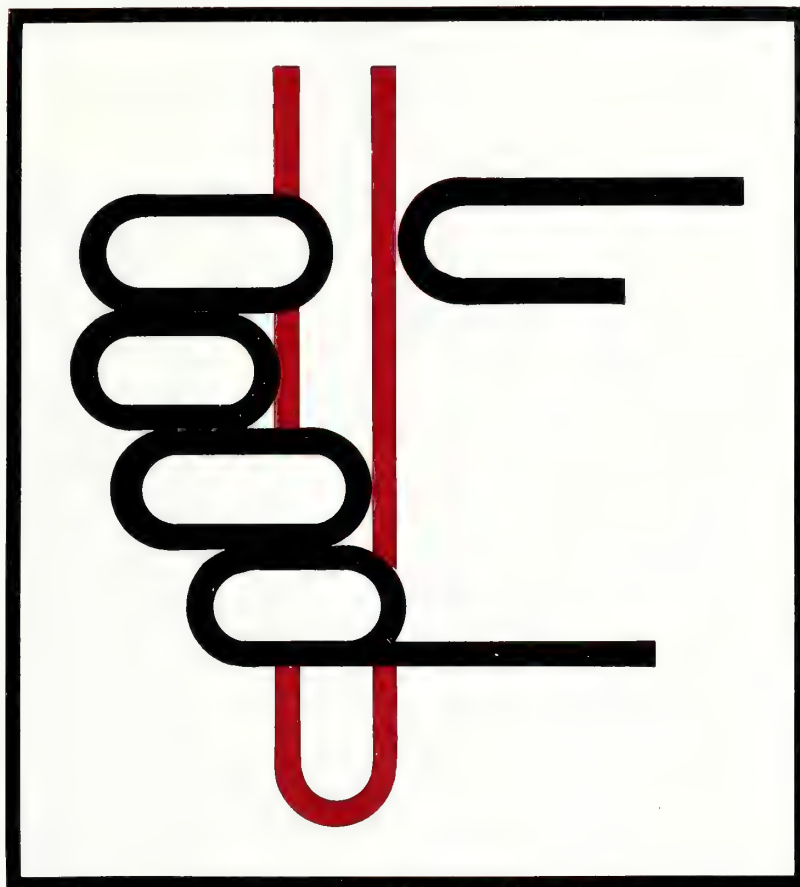
**CORRECTION**—In an October *IMJ* Doctor's News feature, “Physician Placement Service,” readers were instructed to contact the VA Physician Service at an incorrect box number (P.O. Box 791). The correct address is VA Physician Placement Service, P.O. Box 719, Randolph, MA 02368.

The feature announced establishment of the Physician Placement Service, which allows any VA Medical Center in the United States to identify physicians who meet their specialty needs. Physicians need only send one application for any VA Medical Center opening.

The feature indicated that persons outside Massachusetts could also obtain further information by calling 1-800-343-8831.

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The 2-mg tablet is scored, making it easier to initiate therapy with the smallest effective amount, in order to forestall oversedation or ataxia. For most elderly or debilitated patients, 2 to 2½ mg, once or twice daily, is the recommended starting dosage, to be gradually increased or decreased as needed and tolerated.


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## Unmatched range of indications



In both office and hospital practice, only Valium (diazepam/Roche) does so much so well. One reason: Valium can claim not only clinically useful "mind and muscle" effects but anticonvulsant properties as well. The most versatile of the benzodiazepines, Valium is most widely known as a dependable anxiolytic, producing prompt relief of excessive anxiety, whether seen alone or associated with functional or organic disorders. In addition, adjunctive Valium is often an important asset in programs designed to relieve skeletal muscle spasm due to local pathology or to control certain seizure disorders.

Valium fits well into most therapeutic regimens because it is used with many primary medications, such as cardiac glycosides, diuretics, antacids, vasodilators and anticoagulants. The clearance of Valium and certain other benzodiazepines can be delayed by cimetidine administration, but the clinical significance of this is unclear. Patients should be cautioned against drinking alcohol, driving or operating machinery while taking Valium, as with all agents that act on the CNS. Periodic reassessment of the usefulness of continued therapy with Valium is recommended.

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Before prescribing, please see summary of product information on following page.

ROCHE



# Viewbox

(Continued from page 485)

## Diagnosis: Congenital Cystic Adenomatoid Malformation

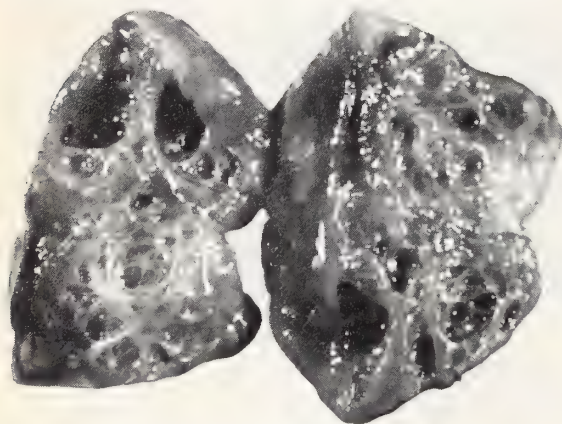


Figure 3

Cut surface of left lung with cystic adenomatoid malformation. There are multiple smooth walled cysts in the lung, which has a bulky appearance.

The first chest film (Figure 1) shows a large multicystic lesion in the left hemithorax and a tension pneumothorax. There is diaphragmatic inversion and mediastinal shift. The bowel gas pattern is normal. After insertion of the chest tube the pneumothorax has resolved but the multicystic area is unchanged (Figure 2). The patient remained in respiratory distress.

At surgery the left lower lobe was found to be hyperinflated and filled the entire left hemithorax, pushing the mediastinum to the right. The left lower lobe contained multiple cysts. A left lower lobectomy was done. The pathologic diagnosis was cystic adenomatoid malformation. The baby did well postoperatively and was discharged one week later.

### Pathology

Cystic adenomatoid malformation shows no predilection for any single lobe. Grossly, the involved portion of the lung is enlarged, heavy, and has a firm rubbery consistency. The cut surface shows smooth walled cysts which communicate with the bronchial tree (Figure 3). These cysts are lined by columnar epithelium, which may be ciliated. There is a marked over-production of bronchiolar tubular structures without alveolar differentiation. No tubular mucus glands are seen. No cartilage is present.<sup>1</sup>

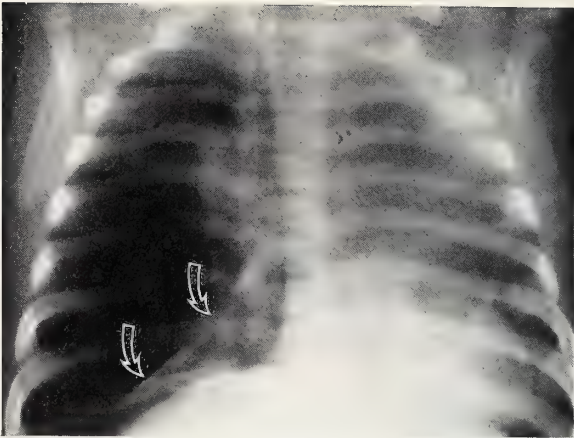


Figure 4

Congenital lobar emphysema of the right middle lobe. A large air filled structure fills most of the right hemithorax, and compresses the right lower lobe (arrows).

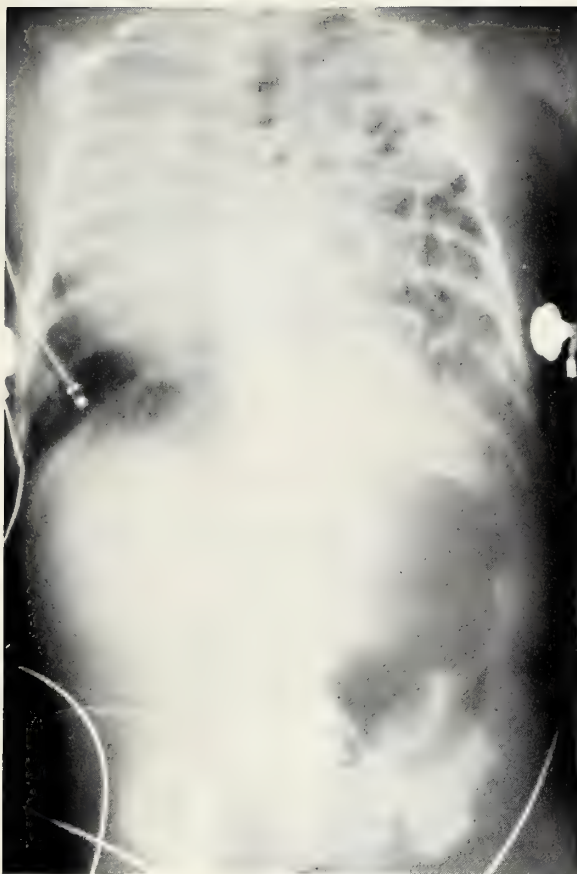
### Clinical

In the neonatal period, cystic adenomatoid malformation presents with progressive respiratory distress. Tachypnea, dyspnea, sternal retractions or nasal flaring may be observed. Physical findings include decreased or absent breath sounds over the cystic area. Heart sounds may be shifted away from the involved hemithorax.

Other abnormalities associated with cystic adenomatoid malformation include anasarca and polyhydramnios. In some children, symptoms are delayed and the lesion is not diagnosed until as late as age 14 years of age. These patients may have recurrent respiratory infections localized to the same portion of the lung or an unresolving pulmonary infiltrate.<sup>2,3</sup>

Table 1 lists causes of cystic patterns in the infant chest in which there is a localized distribution of the cysts.

Table 1	
Congenital	
1.	Congenital lobar emphysema
2.	Congenital cystic adenomatoid malformation
3.	Herniated bowel
4.	Intrapulmonary bronchogenic cyst
5.	Congenital cystic bronchiectasis
6.	Cystic teratoma
Acquired	
1.	Persistent interstitial pulmonary emphysema
2.	Pneumonia with cavitation or pneumatocele



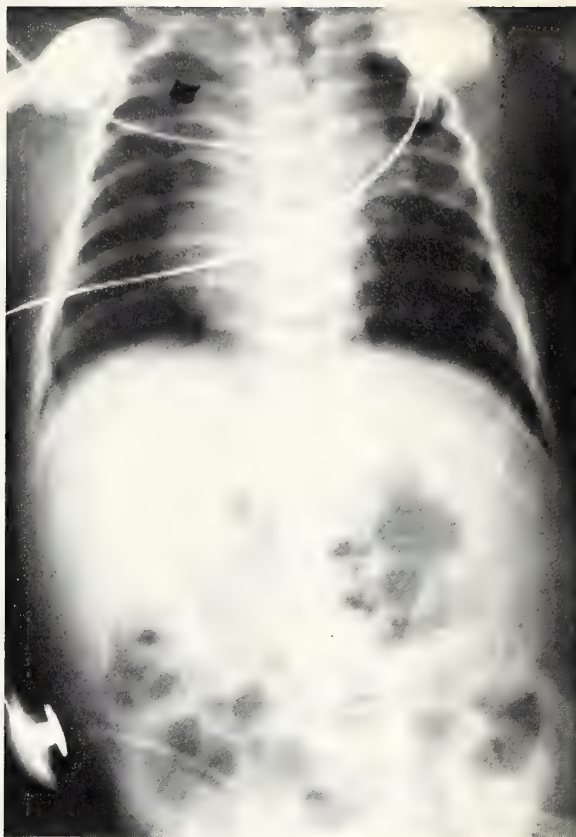
**Figure 5**

**Congenital diaphragmatic hernia through foramen of Bochdalek. The chest shows multiple thick walled cystic structures in the left hemithorax, some of which contain fluid. The mediastinum is shifted to the right. The abdomen shows a distended stomach with almost no other bowel gas.**

### **Radiology**

The most common radiographic appearance of cystic adenomatoid malformation is a multicystic lesion in which the cysts vary in size from .5 to 3cm. If the cysts are entirely fluid filled, a homogeneous mass is seen. When the cysts are partially fluid filled, there will be multiple air-fluid levels on upright or decubitus chest radiographs. When totally air filled, the radiographic appearance is simply that of a multicystic lesion.

Typically, the lesion has a dense rim composed of surrounding atelectatic lung and nonexpanded epithelial lined cysts. Occasionally one cyst may markedly enlarge and dominate the radiographic picture by producing a single lucent area. If this occurs, it may be difficult to differentiate congenital lobar emphysema from cystic adenoma-



**Figure 6**

**Postoperative film shows heart, lungs, and abdomen to be normal. Note normal abdominal gas pattern.**

toid malformation. However, the surrounding lung should still show some abnormal density corresponding to less distended cysts.<sup>4,5</sup>

Since a cystic adenomatoid malformation communicates with a bronchus it is very common to see massive expansion of the multicystic lesion. This leads to diaphragmatic inversion, mediastinal shift and pulmonary herniation. It is the mediastinal displacement and pulmonary compression caused by the expanding cystic lesion that lead to acute progressive respiratory distress.

### **Differential Diagnosis**

The primary radiographic finding of congenital lobar emphysema is over distention of a single lobe. The LUL, RUL, and RML are most frequently involved (Figure 4). Compression atelectasis of surrounding lung and shift of mediastinal structures can occur. The hemidiaphragm may be depressed. If untreated, progressive respiratory distress can occur. Our case demonstrates multiple cystic lesions in the LLL, thus it is unlikely to be an emphysematous lobe.



More than 80% of all congenital diaphragmatic hernias occur on the left through the foramen of Bochdalek (Figure 5, 6). Radiographically, there is air in multiple loops of intestine within the left hemithorax, and only a few loops of air-filled bowel in the abdomen. The herniation may involve colon, small bowel, stomach, liver, kidney, spleen or omentum. Contrast media may be given orally to demonstrate bowel loops in the chest. Our patient showed an essentially normal gas pattern in the abdomen in terms of amount of gas and position of loops. Although this doesn't exclude hernia, it makes it less likely.

Staphylococcal pneumonia with pneumatocele is not a congenital cause of cystic lung disease and should not be considered here.

Intrapulmonary bronchogenic cysts seldom communicate with the bronchial tree but can present as air filled cystic spaces within the lung. However these are usually solitary and not likely to be confused with cystic adenomatoid malformation.

### Treatment

The clinical presentation and subsequent management varies with the age at presentation. The neonate who presents with acute respiratory distress is a surgical emergency. If therapy is delayed, progressive expansion of the cysts may produce further atelectatic changes in the lung parenchyma surrounding the affected tissue leading to increas-

ing respiratory distress. In addition, the increased intrathoracic pressure caused by the expanding cyst leads to decreased venous return and can compromise cardiac function.

After the neonatal period, an untreated malformation has a chronic course and may be asymptomatic for years. Indications for surgery include progressive enlargement and increasing symptoms including chronic or recurrent respiratory infections.

Lobectomy is the treatment of choice. Infants who have had lobectomy have been shown to have a decreased incidence of postoperative morbidity and shorter hospitalization as compared to those treated by simple excision or segmental resection.<sup>6</sup> ◀

### References

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2. Stocker, J.T., Madewall, J.E., Drake, R.M.: "Congenital Cystic Adenomatoid Malformation of the Lung," *Human Pathology*, March 1977; 8(2):155-171.
3. Wolf, S.A., Hertzler, J.H., Philippart, A.L.: "Cystic Adenomatoid Dysplasia of the Lung," *J Ped Surg* 1980; 15(6):925-930.
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5. Wesenberg, R.L.: "THE NEWBORN CHEST." Harper and Rowe, Hagerstown, Maryland, pp 193-198, 1973.
6. Nishibayashi, S.W., Andrassy, R.J., Wooley, M.M.: *J Ped Surg* 1981; 16(5):704-706.

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## "I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National

Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

February 1	Illinois Interagency Council on Smoking & Disease	Chicago Daley Center
February 3	Peoria Health Department	Peoria
February 16	St. Mary Hospital	Quincy
March 1	Illinois Interagency Council on Smoking & Disease	Chicago Daley Center
April 5	Illinois Interagency Council on Smoking & Disease	Chicago Daley Center

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# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ANNA: FAMILY PRACTITIONER.** Excellent practice opportunity. Join young group of board-certified internists, family practitioner providing comprehensive health care for two counties in beautiful, wooded southern Illinois. Office adjacent to community hospital. Major state university (20 miles away), with medical school offers opportunity for affiliation. Administrative support provided. Guaranteed salary, bonus, fringes. Contact Susan Casey, Rural Health, Inc., 517 North Main Street, Anna 62906 (618-833-4471). (1)

**AURORA:** Dreyer Medical Clinic, S.C. Openings for Internal Medicine, Rheumatology, OB-Gyn & Urology in well established clinic of 42 physicians with associated satellite in rapidly growing area. Contact: L.E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506, 312-859-6700. (1)

**CARBONDALE:** 30 physician multi-specialty group needs pediatrician, orthopedic surgeon, radiologist. Excellent salary first year. Corporate shareholder after first year. Superior fringe benefits. University community with medical school affiliation available. All recreational facilities nearby. Contact Wayne Given, 2601 W. Main, Carbondale, 62901 (618) 549-5361 (12).

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**FREEPORT:** Cardiologist—Otolaryngologist—Urologist—Positions available in 20 physician multi-specialty clinic. This 30 year old group practices in a new clinic facility across from a recently expanded general hospital in a midwestern community of 30,000. Competitive salary and excellent benefit program provided. Contact W. C. Sharelis, M.D., Medical Director, Freeport Clinic, S. C., 1036 W. Stephenson St., Freeport 61032, 815-235-5111. (12)

**GENEVA: SMALL TOWN MEDICINE/BIG CITY ADVANTAGES—**Seeking physician to join board certified active family practice group. Thriving community of 10,000, west of Chicago. Modern, well equipped, 3 physician office with full lab and x-ray facilities. 110 bed primary care hospital 1 mile from office. Salary guarantee, malpractice coverage, other benefits. Opportunity for full partnership. Send resume and C.V. to: P.O. Box 72, Geneva, Illinois 60134. (3)

**GRIGGSVILLE:** North Pike County Population 3000. Remodeled clinic available, equipped with supplies and basic equipment. Ten county physicians. Fifty miles from Quincy and 70 miles from Springfield. Recreational areas nearby. CONTACT: Harry Kopps, Box 421, Griggsville, 62340, (217-833-2030).(1)

**LA HARPE:**—Population 1200. Seeking replacement for one of two Family Physicians in community. 64 bed hospital including 49 long term; affiliation with nearby regional medical center; office facilities and financial assistance available. Educational/recreational facilities—Mississippi River nearby. Contact: Richard Miller, Administrator, La Harpe Hospital, La Harpe 61450, 217/659-3011. (3)

**MUNSTER, IND. FAMILY PRACTICE-GP's:** immediate need for primary care in large suburban multispecialty clinic. No OB. Excellent on site diagnostic available-including CT scan. 1st yr guarantee plus incentive. Partnership after 1 yr. No investment required. Contact: T. R. Hofferth, Director; Hammond Clinic, 7905 Calumet Ave., Munster, IN., 46321 (219) 836-5800 Collect. (1)

**PINCKNEYVILLE:** County Seat. 30 minutes to SIU-Carbondale. 75 minutes to St. Louis. Recent expansion of facilities provides space for a family practice physician to join three family practice physicians and a general surgeon. Lab, X-ray, and emergency room. Pharmacy on premises. Hospital one block away. Financial assistance available. Partnership status after one year. CONTACT: C. E. Cawvey, M.D., 206 North Main, Pinckneyville, 62274, 618-357-2131. (1).

**PRINCETON—**60 miles north of Peoria. Need orthopedic surgeon to join established practice. Need specialist in internal medicine. Need anesthesiologist. Twenty-three doctors on active medical staff. Stable community. CONTACT: William H. Spitler; Associate Administrator, Perry Memorial Hospital; 530 Park Avenue East; Princeton, 61356; (815) 875-2811. (12)

**ROBINSON:** Service area 20,000. 107 bed JCAH hospital in economically sound area. The hospital is currently recruiting an ob-gyn, general surgeon, orthopedic surgeon, and ophthalmologist. Comprehensive recruitment package offered includes: salary guarantee, office rent, office help and relocation expenses. Current plans include construction of a new physicians' office building. Family oriented environment. Contact Carleton King, 1000 N. Allen, Robinson, 62454. (618) 544-3131. (12)

**ROSICLARE: FAMILY PRACTITIONER/INTERNAL MEDICINE**—53-bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forest. Each physician is provided his/her own five room clinic adjacent to the hospital. CONTACT Roby Williams, Administrator, P.O. Box 467, Rosiclare 62982. (618) 285-6634. (3)

**STERLING-ROCK FALLS:** Total population near 30,000. Two hours from Chicago, 1½ from Rockford and Peoria, one from Quad Cities. Outstanding recreational facilities. Modern 150-bed JCAH hospital; youngish medical staff, most specialties. No nurse shortage. Private or group practices. CONTACT: Darryl Wahler, CEO, Community General Hospital, 1601 First Avenue, Sterling, 61081, 815-625-0400. (1)

**STREATOR:** Otolaryngologist and neurologist needed as support to staff of 249-bed facility in North Central Illinois—Service area of 50,000—Excellent potential—Attractive office facilities close to hospital available—Financial assistance obtainable. Contact Terence Schuessler, Administrator, St. Mary's Hospital, Streator (815-673-2311). (1)

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Executive Vice-President



# Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510, Chicago, IL 60603, (312) 236-6110.

*Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.*

## JANUARY

### Family Medicine

#### Winter Refresher Course for Family Physicians

**For:** FP's. Lectures/Workshops, Jan. 26-28, Milwaukee, WI. **Sponsor:** Dept. of Family Practice, Medical College of Wisconsin, 2200 W. Kilbourn Ave., Milwaukee, WI 53233. **Fee:** \$200. **Credit:** Category 1, 21 hours; AAFP Prescribed, 21 hours. **Contact:** Susanna Rechlitz. **Phone:** 414/931-1030.

### Family Practice

#### Family Practice Seminar-at-Sea

**For:** MD's. Symposium/Cruise, Jan. 22-Feb. 1, Caribbean. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1, 48 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Family Medicine

#### Results of Recent Advances in Medicine

**For:** Pediatricians, Internists, FP's. Symposium, Jan. 17-19, Telemark Lodge, Cable, WI. **Sponsor:** U of WI, CME, 610 Walnut St., Madison, WI 53706. **Fee:** \$235. **Credit:** Category 1, 14 hours; AAFP Prescribed, 14 hours. **Contact:** Ann Bailey. **Phone:** 608/263-2854.

### Headache

#### Diagnosis & Treatment of Headache

**For:** MD's, DO's. Workshop, Jan. 13-15, Marriott's Camelback Inn, Scottsdale, AZ. **Sponsor:** American Association for the Study of Headache, 5252 N. Western Ave., Chicago 60625. **Reg. deadline:** 11/10. **Fee:** \$275. **Reg. limit:** 300. **Credit:** Category 1, 15 hours; AAFP Prescribed, 15 hours; AOA, 2-D. **Contact:** Seymour Diamond.

### Internal Medicine

#### The Year in Internal Medicine

**For:** Internists, FP's, GP's. Lecture, Jan. 26-29, Chicago. **Sponsor:** Northwestern University Medical School, CME, 301 E. Chicago Ave., Chicago 60611. **Reg. fee:** \$200. **Credit:** Category 1, 20 hours. **Contact:** Paula Puntney. **Phone:** 312/649-8533.

### Pathology

#### Liver & GI Clinico-Pathologic Conference

**For:** MD's. Lecture, Jan. 25, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

### Pathology

#### Biochemical Evaluation of Pancreatic Disease

**For:** Pathologists. Lecture, Jan. 10, 7:30 p.m., Drake Hotel, Chicago. **Sponsor:** Chicago Pathology Society, c/o Marshall Short, MD, Loretto Hospital, 645 S. Central Ave., Chicago 60644. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Marshall Short, MD. **Phone:** 312/626-4300 x 383.

## Pediatrics

### Chronic Pulmonary Disease in Pediatrics

**For:** Pediatricians. Symposium, Jan. 14-15, Chicago. **Sponsor:** Children's Memorial Hospital, Dept. of Clinical Dietetics, 2300 Children's Plaza, Chicago 60614. **Reg. deadline:** 1/7. **Fee:** \$30. **Reg. limit:** 200. **Credit:** Category 1, 8 hours. **Contact:** Roberta Cooper. **Phone:** 312/880-4793 x 4792.

## Pharmacology

### RX: Pharmacology '83

**For:** MD's. Symposium, Jan. 13, 1:00 p.m., Lincoln. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** \$45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Surgery

### Specialty Review in Thoracic Surgery

**For:** General & Cardiothoracic Surgeons. Lecture, Jan 24 (6 days), Chicago. **Speaker:** Sidney Levitsky, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$450. **Reg. limit:** 200. **Credit:** Category 1, 48 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Urology

### Genitourinary Pathology

**For:** Urologists. Course, Jan. 27-30, Airport Marriott, St. Louis, MO. **Sponsor:** American Urological Assn., P. O. Box 25147, Houston, TX 77265. **Reg. deadline:** 1/27. **Fee:** \$230, member; \$260, non-member. **Reg. limit:** 150. **Credit:** Category 1, 16 hours. **Contact:** Alice Henderson. **Phone:** 713/790-6070.

### Urologic Pathology & Radiology

**For:** Urologists. Lecture, Jan. 17 (5 days), Chicago. **Speaker:** Thomas John, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Urology

## FEBRUARY

### Family Practice

#### Advances in Family Practice

**For:** GP's, FP's. Lecture, Feb. 14 (5 days), Chicago. **Speaker:** Harry Marchmont-Robinson, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$350. **Reg. limit:** 150. **Credit:** Category 1, 35 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

### Gastroenterology

#### Gastrointestinal Endoscopy

**For:** MD's. Lectures/workshops, Feb. 23-26, Milwaukee, WI. **Sponsor:** Section of Gastroenterology, Medical College of Wisconsin, P. O. Box 1608, Milwaukee, WI 53201. **Fee:** \$350. **Reg. limit:** 250. **Credit:** Category 1, 25 hours; AAFP Elective, 25 hours. **Contact:** Walter Hogan, MD. **Phone:** 414/931-1030.

### Medical Education

#### Problem Based Learning

**For:** MD's. Workshop, Feb. 14-18, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** yes. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Medical Education

#### Simulated/Standardized Patients: Training & Use

**For:** MD's. Workshop, Feb. 21-23, Springfield. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** yes. **Reg. limit:** yes. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

### Neurology

#### Basic Science of Neurology

**For:** Neurologists, Psychiatrists. Lecture, Feb. 21 (5 days), Chicago. **Speaker:** John Hughes, MD, PhD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$400. **Reg. limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## MEDICAL AUDIT & CME PLANNING

*Despite disappointments, many hospitals do shape their audits and other quality assurance procedures to support and enhance physician learning. This ICCME handbook offers one effective approach to audits that requires minimum physician time. Includes sample medical records analysis sheets for seven diagnoses, developed at Methodist Medical Center, Peoria.*

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## Neurosurgery

### Review Course in Neurological Surgery

**For:** Neurosurgeons, Neurologists. Lecture, Feb. 4 (10 days), Chicago. **Speaker:** Leonard Kratzler, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$675. **Reg. limit:** 250. **Credit:** Category 1, 101 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Pathology

### Liver and GI Clinico-Pathologic Conferences

**For:** MD's. Lecture, February 22, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Road, North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Pediatrics

### Pediatric Neurology: Review & Clinical Update

**For:** Pediatricians. Lecture, Feb. 28 (3 days), Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Speaker:** Lawrence Tomasi, MD, PhD. **Fee:** \$275. **Reg. limit:** 90. **Credit:** Category 1, 24 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

### Specialty Review in General Surgery, Part II

**For:** General & Specializing Surgeons. Lecture, Feb. 21 (11 days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** \$600. **Reg. limit:** 300. **Credit:** Category 1, 100 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

## Surgery

### Arterial Occlusive Disease of the Neck

**For:** Surgeons. Symposium, Feb. 10, 1:00-5:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** \$45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## MARCH

## Medicine

### Basic Mechanisms & Clinical Management of Shock

**For:** MD's. Symposium, March 3, 1:00-5:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** \$45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Medicine

### Dysfunctional Uterine Bleeding and Evaluation and Treatment of Infertility

**For:** MD's. Symposium, March 10, 1:00-5:00 p.m., Pickneyville. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** \$45. **Reg. limit:** none. **Credit:** Category 1, 5 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Medicine

### Update on Arthritis

**For:** MD's. Symposium, March 10, 3:00-8:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** \$45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Medicine

### Use and Abuse of Antibiotics

**For:** MD's. Symposium, March 31, 1:00-5:00 p.m., Flora. **Sponsor:** SIU School of Medicine, P. O. Box 3926, Springfield 62708. **Fee:** \$45. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

## Ophthalmology

### Current Concepts Seminar

**For:** Ophthalmologists. Symposium/workshops, March 10-11, The Concourse Hotel, Madison, WI. **Fee:** TBA. **Reg. limit:** none. **Credit:** TBA. **Sponsor:** U of Wisconsin—Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Pathology

### Clinical Pathological Evaluation of Thyroid Nodules

**For:** MD's. Lecture, March 14, 7:00 p.m., Chicago. **Speaker:** J. I. Hamburger, MD. **Sponsor:** Chicago Pathologic Society, c/o Marshall Short, MD, 645 S. Central Ave., Chicago 60644. **Reg. deadline:** 3/4. **Fee:** dinner only. **Reg. limit:** none. **Credit:** Category 1, 2 hours. **Contact:** Harriet Callihan. **Phone:** 312/663-0040.

## Pathology

### Liver & GI Clinico-Pathologic Conference

**For:** MD's. Lecture, March 29, 4:30 p.m., North Chicago. **Sponsor:** Dept. of Pathology, UHS/CMS, 3333 Green Bay Rd., North Chicago 60064. **Fee:** none. **Credit:** Category 1, 2 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

## Pulmonary Diseases

### Chronic Obstructive Pulmonary Diseases

**For:** MD's. Symposium/workshops, March 3-4, Madison, WI. **Sponsor:** U of Wisconsin—Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** TBA. **Reg. limit:** none. **Credit:** TBA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

## Sports Medicine

### Sports Medicine Seminar

**For:** MD's, physical therapists. Seminar, March 12, 8:00 a.m.-5:00 p.m., St. Charles. **Sponsor:** St. Charles High School, Dunham Rd., St. Charles 60174. **Contact:** Don Nielsen. **Phone:** 312/584-1100.

## Medicine for Today

### 32nd Annual Program Illinois Academy of Family Physicians

### Spring Sessions February—March, 1983

Credit: 15 hours, AMA Category 1 and AAFP Prescribed. Fee: \$75, members; \$85, non-members.

For further information concerning dates and location nearest you, contact: Illinois Academy of Family Physicians, 1200 Harger Road, Suite 405, Oak Brook, IL 60522, (312) 325-8502.

## Independent Study

The University of Wisconsin offers a number of courses for primary care physicians that enable you to continue learning in the privacy of your home or office, studying at your convenience. Available are:

- Pharmacology
- Infectious Diseases
- Pediatrics
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Each course carries Category 1 credit, ranging from 30 to 45 hours. Each is updated regularly.

For complete details, write or call:

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WARF Bldg.  
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(608) 263-2853

## REMINDER TO ILLINOIS CME SPONSORS

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To arrange for a personal consultation (no charge), contact the Illinois Council on Continuing Medical Education at (312) 236-6110.



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## POSITIONS AND PRACTICE

**U.S. AIR FORCE MEDICAL CORPS** is currently accepting applications for physicians in the following specialties: Surgery (All subspecialties), Obstetrics/Gynecology, Otorhinolaryngology, Anesthesiology, Urology, Rheumatology, Neurology, Psychiatry. For further information contact: Capt. Brian Legg (312) 263-1207. Call collect or send CV to 111 N. Wabash, Suite 1805, Chicago, Illinois 60602.

**OTOLARYNGOLOGIST**—Excellent opportunity for full or part-time combined practice with ophthalmologist located 80 miles SW of Chicago. Tuesday and Friday office hours advisable with Thursday surgical day. Contact: Ms. A. Burnett, (800) 223-4500 or write Box #1051 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**OPHTHALMOLOGY/LOCUM TENENS OR ASSOCIATION**—Opportunity for surgical assisting, office, glaucoma management, refraction and eye care located 80 miles from Chicago. Contact: Ms. A. Burnett (800) 223-4500 or write Box #1051 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**ILLINOIS, CHICAGO: EXPERIENCED EMERGENCY PHYSICIANS** needed for progressive community hospital. Excellent salary and benefits. Good specialty backup. Send resume to P.O. Box 921, Oak Brook, IL 60521, or call 312-986-5870.

**PRIMARY CARE PHYSICIANS** wanted to practice quality medicine in well-equipped, 117 bed JCAH accredited, full service community hospital, linked with tertiary care center 60 miles away. Thriving East Central Illinois community in low crime area offers abundant cultural, educational, and recreational opportunities. Income guarantee and other financial assistance. Write to Box #1055 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.

**PARIS: PRACTICE OPPORTUNITY** available. Physician (FP) planning to retire is interested in someone to take over practice. Population area over 10,000. Modern hospital facilities and complete office available. Picker X-ray machine. Contact: Dr. G. M. Churukian, 406 S. Main St., Paris, IL 61944; (217) 463-4560.

**RE: LOCUM TENENS**—General family practice with geriatric interest for two months during the summer of 1983. If interested, please contact Suite 306, 1221 East State Street, Rockford, Illinois 61108.

**SMALL TOWN MEDICINE/BIG CITY ADVANTAGES**—Seeking physician to join board certified active family practice group. Thriving community of 10,000, west of Chicago. Modern, well equipped, 3 physician office with full lab and x-ray facilities. 110 bed primary care hospital 1 mile from office. Salary guarantee, malpractice coverage, other benefits. Opportunity for full partnership. Send resume and C.V. to: P.O. Box 72, Geneva, Illinois 60134.

**EMERGENCY PHYSICIANS:** St. Louis Bi-State area hospitals; emergency physicians, family practitioners, and internists desiring emergency medicine are needed. Positions open for staff and directorship; \$85,000-\$90,000 per year for a 48 hour week. Malpractice, vacations, and CME conventions paid for. For information, send C.V. to TRAUMA SYSTEMS, INC., 12140 Woodcrest Executive Dr., Suite 280, St. Louis, MO 63141; phone 314-576-7071.

**CURRENT OPENINGS FOR PHYSICIANS** of all specialties in the Illinois area and nationwide. Opportunities in Solo, Hospital and Clinic based positions. For further information please contact Physicians Recruiters Inc. at (312) 724-7001. All inquiries will be handled on a confidential basis.

**GROW WITH US IN THE SUNBELT**—The INA Healthplan needs physicians in family practice and most specialties in Miami, Tampa, Dallas, Houston, Phoenix, Tucson and Los Angeles. Attractive salaries and comprehensive benefits including professional development, retirement and profit sharing programs are provided. If team interaction and casual living interest you, send a brief CV to Medical Administration, INA Healthplan, Inc., 7616 LBJ Freeway, Suite 303, Dallas, Texas 75251.

**NEUROLOGIST WANTED**—To join a very busy, well established neurosurgeon in North Central Wisconsin. Active practice assured, extremely good income potential. New modern office located in a new hospital. Excellent community approximately 65,000 population with unlimited outdoor recreation and very good school systems. For more information contact Lloyd Engstrom. Call collect 715/842-3202 or write P.O. Box 1646, Wausau, Wisconsin 54401

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**FAMILY PRACTICE, INTERNAL MEDICINE, OB/GYN, GENERAL AND ORTHOPEDIC SURGERY, ENT, RADIOLOGY, PSYCHIATRY, OPHTHALMOLOGY** wanted to join stimulating prepaid practice in Dallas, TX—a cosmopolitan city whose climate and economy shines. Established physician group enjoys competitive salaries and comprehensive benefits while practicing in excellent facilities, free from office management. For further information, send C.V. to: Medical Director—IMJ, INA Healthplan of Texas 8131 L.B.J. Suite 350 Dallas, TX 75251 (214) 669-8069.

**FAMILY PRACTITIONER**, licensed in Illinois, board eligible/certified, American trained, to join established group in busy near north side, modern office. Please send curriculum vitae to: Box #1068 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

**FAMILY PRACTITIONER**—To locate in Rosiclare, Illinois. 53-bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forrest. Each physician is provided his/her own five room clinic adjacent to the hospital. CONTACT Roby Williams, Administrator, P.O. Box 467, Rosiclare, IL 62982. (618) 285-6634.

**UNIVERSITY HEALTH SERVICE:** gynecologist or generalist for women's health program, willing to work in team approach. Routine gynecological care, family planning services, health education, supervising nurse practitioners, Board certification preferred. Illinois license or eligibility for license by time of appointment. Campus of 26,000 1½ hours from downtown Chicago. Position available January 1983. For further information and application contact Director, University Health Service, Northern Illinois University, DeKalb, Illinois 60115. 815-753-1311, ext. 232. EEO/AA employer. Applications will be accepted until the position is filled.

**YOUNG ORTHOPEDIC SPECIALISTS** needed for fast growing orthopedic office in the northwest suburbs. Please mail resume to: P.O. Box 1494, Arlington Heights, IL 60004.

**OBSTETRICIAN/GYNECOLOGIST FOR FAMILY PLANNING CLINIC** Part-time clinician for expanding Family Planning Clinic. Afternoons or evening hours available. Write or Call: DuPage County Health Department 111 North County Farm Road, Wheaton, IL 60187 (312) 682-7558.

**ASSOCIATE AND PARTNER** for General Medicine Practice, Southeast Suburb. Possible short-term buyout. Suite 721, 80 River Oaks Center, Calumet City, IL 60409.

**IMMEDIATE OPENING FOR FAMILY PRACTITIONER** in Lake Preston, S. Dak. New hospital with 65 bed nursing home attached and new clinic. Excellent financial opportunity near cultural centers: offers wholesome environment plus serving people that appreciate your work. Call (605) 847-4451 or (605) 847-4452.

**PEDIATRICIAN**—To cover vacationing pediatrician February 22 through March 12, 1983. DeKalb, Illinois. 60 Miles from Chicago Loop. Send resume to: Pediatrics, Wiltberger Bldg. 901 N. First, DeKalb, IL 60115.

## SITUATIONS WANTED

**OCCUPATIONAL MEDICINE—INTERNIST, PART TIME.** Experienced in occupational medicine, industrial trauma, executive physicals, internal medicine. Write to Box #1061 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago 60603.

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**PRACTICE WANTED**—American Internist—Gastroenterologist interested in quality practice in internal medicine, or gastroenterology or internal medicine-gastroenterology in Chicago, western, northwestern or northern suburbs. Will share, rent or purchase. Write to Box #1067 c/o Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, IL 60634.

**PODIATRIST** Wishes to affiliate with medical group. Seeks practice opportunity or salaried position. Interested in surgery, general practice and sports medicine. Chicago or suburbs contact Box #1066 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.

**FAMILY PRACTITIONER**, Illinois licensed, American born & trained, relocating to Chicago/North-Northwest Suburbs. Seeks full time association with group (Family Practice or Multispecialty) involved in quality Private, HMO or Industrial practice. Write to Box #152, 606 W. Barry, Chicago, Ill., 60657.

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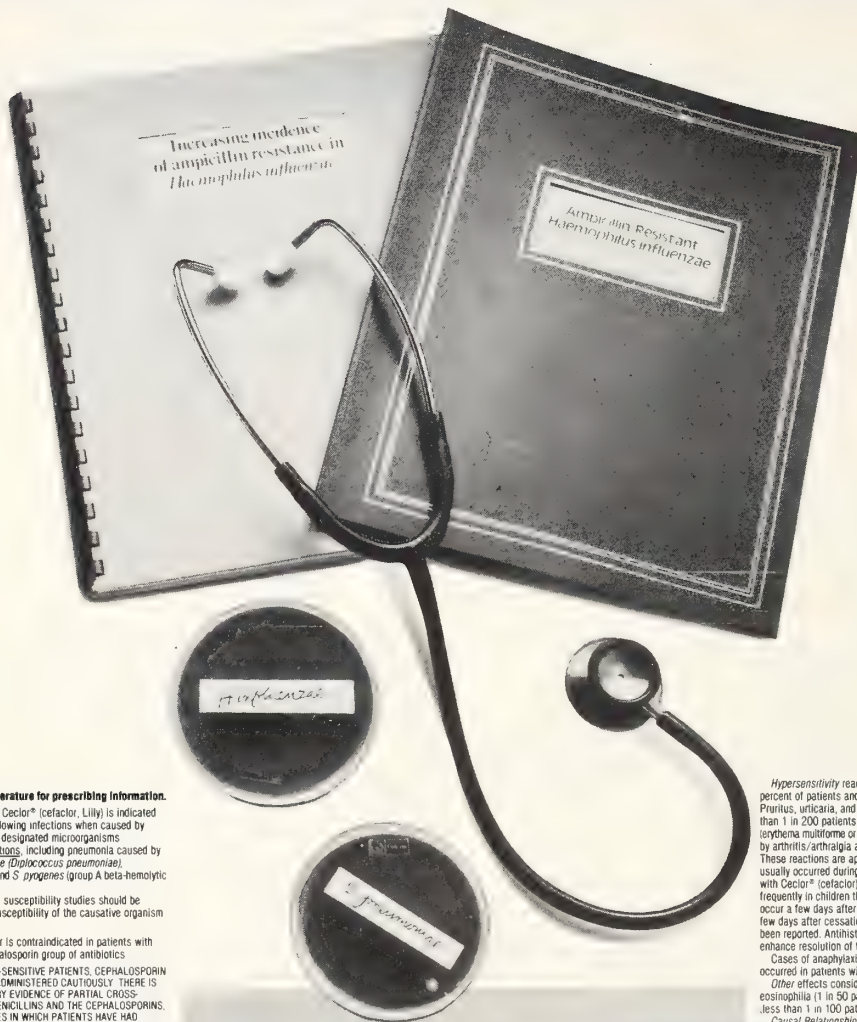
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# An added complication... in the treatment of bacterial bronchitis\*



## Brief Summary.

Consult the package literature for prescribing information.

**Indications and Usage:** Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

**Lower respiratory infections:** including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

**Contraindication:** Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS: CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES. Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

**Usage in Pregnancy:** Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

**Usage in Infancy:** Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** Adverse effects considered related to cefclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefclor.

## Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis\*—are sensitive to treatment with Cefclor.<sup>1-6</sup>

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.<sup>7</sup>

# Cefclor®

## cefclor

Pulvules®, 250 and 500 mg

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor® (cefclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship Uncertain:** Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Hepatic:** Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Hematopoietic:** Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

**Renal:** Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

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\*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc. Carolina, Puerto Rico 00630.

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# REPORT

## FOR *Illinois Physicians*

### Special Surgical Procedure Program Announced

Blue Cross and Blue Shield of Illinois is pleased to announce its Special Surgical Procedure Program (SSPP) designed to impact positively on the cost of health care.

Starting January 1, 1983, the Plan will pay a physician an additional allowance for the cost of supplies used in performing the following surgical procedures when they are performed in his office:

- Dilation and Curettage
- Excision of Ganglion
- Puncture Aspiration of Douglas Cul-de-Sac

#### ENDOSCOPIES

(Rigid or Fiberoptic with or without Biopsy)

- Arthroscopy
- Bronchoscopy
- Colonoscopy
- Cystoscopy
- Esophagogastrosocopy
- Esophagoscopy
- Gastrosocopy
- Laparoscopy, with or without tubal ligation
- Laryngoscopy
- Proctosigmoidoscopy
- Triple Upper Endoscopy

The program was announced on November 5, 1982 in a letter to physicians who reported performing one or more of the listed procedures in 1981.

*The SSPP is available to any physician in the State.*

When you submit your fee for any of the listed procedures when it is performed in your office, please do *not* itemize the cost of supplies. Include this cost in your fee and indicate on your claim form that the procedure was performed in your office. Payment will be based upon the individual member's Blue Cross and Blue Shield benefit program. (That is, an indemnity schedule of usual and customary allowance with any applicable co-payments and deductibles.) With the information submitted by physicians participating in the program, we will then calculate a separate usual and customary allowance for the cost of supplies for each procedure.

We hope you will agree that SSPP represents another step being taken by Blue Cross and Blue Shield of Illinois in response to suggestions from the physician community in our continuing, mutual efforts to find ways to reduce expenditures for health care services for our members.

If the procedures listed above had been performed in the office 10 percent of the time last year rather than in an institutional setting, we estimate that over \$4 million would have been saved for our members.

### Symposium VII Draws Record Crowd

President S. Martin Hickman welcomed a standing room only crowd to the 7th Annual Blue Cross and Blue Shield of Illinois Symposium on November 18 at the Hyatt Regency Chicago.

"In welcoming you," Hickman said, "I want to remind you that our Symposia have never served as a platform for a single point of view or a special interest, not even our own."

More than 1,100 business, health care, labor union, government, financial and consumer leaders were on hand for the opening of the Symposium. The theme of the day-long event was "The Health Care System: Forces for Change."

Also greeting the audience was Bernard Tresnowski, president of the Blue Cross and Blue Shield Association.

Hickman told the assembly that the purpose of the Symposium is to ferret out "fresh ideas" from "many perspectives."

"Over the history of this event, I cannot think of a single point of view that has been missed," said Hickman, adding this has clearly proved "there is certainly no monopoly on good ideas."

Tresnowski hailed the Symposium concept, saying "the timing of this conference is excellent" as all sectors of our society are placing great priority on health care.

As the audience settled in for the day's program, Tresnowski urged that they keep in mind the nation has increasingly accepted the concept that "health care is a

*continued on next page*



right for all.” In connection with this belief, it was accepted that health care costs would never exceed 9 percent of the gross national product (GNP) and health care inflation could be controlled through increased productivity.

Tresnowski said our assumptions have proved incorrect as the cost of health care has soared to nearly 10 percent of the GNP. He warned that there is a shift in moods in the land, a growing movement to limit the accessibility of health care.

The shape of the health care system for the future is now being molded and, Tresnowski urged the audience, “we all must get involved.”

Hickman also noted that a few years ago many Symposium speakers talked about that “winds of change” that would sweep through the health care system.

“In my opinion, those winds have turned into a tornado and there is no eye of the storm in sight,” said Hickman.

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## **Arnold S. Relman, M.D.** *“Private enterprise in Health Care”*

For profit providers of health care services came under heavy attack when Arnold S. Relman, M.D. took the podium.

Labeling the for profit providers as the “new medical industrial complex,” Dr. Relman said proprietary hospitals are failing to provide care to any one who cannot afford such care. These institutions shun the indigent as well as those covered by Medicaid and Medicare, he said.

Dr. Relman expressed concern that the problem will grow, noting that the for profit segment of the hospital industry now accounts for about 20 percent of the health care market.

Further, proprietary hospitals are now essentially under the control of five major corporations.

Dr. Relman, who is editor of the *New England Journal of Medicine*, said data clearly shows that the for profit hospitals have failed to live up to their promise of providing more cost efficient health care services. In fact, for profit hospitals charge 17 percent of 24 percent more than non-profit hospitals for comparable services.

A favorite tack taken by the proprietary hospitals is to set room and board charges at a breakeven point or even operate at a slight loss, he said. The institutions then make large profits by “overpricing” ancillary services, by “doing more tests and charging more for them,” said Dr. Relman.

As a result, Dr. Relman favored the development of

prepayment programs because they effectively control costs.

However, Dr. Relman warned that this may well pose another danger. Noting that prepayment plans require cost cutting, he said he has “confidence the investor owned hospitals will cut costs.

“My concern is what will happen to quality, equity and accessibility,” said Dr. Relman.

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## **John E. Affeldt, M.D.** *“The Role of Quality Assurance in a Rapidly Changing Environment”*

A key element in containing the cost of health care services is quality assurance, according to John E. Affeldt, M.D.

America is unique in this regard, being one of only three nations in the world to have a private, voluntary system of reviewing and maintaining quality assurance in hospitals, said Dr. Affeldt.

The physician, who serves as president of the Joint Committee on Accreditation of Hospitals (JCAH), said the key role of his organization is to not only monitor the quality of care, but to bring about measurable improvements.

Furthermore, JCAH is providing the only national mechanism for assessing the effectiveness of hospital quality assurance programs.

Dr. Affeldt said JCAH’s current quality assurance effort dates from 1979 when the organization adopted a new set of standards in this area. The result has been coordinated, integrated hospital-wide quality assurance programs.

The JCAH chief also threw his support behind the efforts of President Ronald Reagan’s Administration to streamline the entire area of federal regulation and oversight of health care providers. He said the result will be better Medicare mandated quality assurance programs as required by the Health Care Financing Authority.

Dr. Affeldt noted the JCAH is now moving into new areas of involvement. For example, standards for the accreditation of hospices are now being developed and a decision will soon be made as to whether JCAH will accredit these providers.

The JCAH has already assumed a key role in monitoring the rapidly expanding ambulatory surgical centers, and will assume similar roles as new types of non-traditional providers evolve.

# Medicaid-Medicare-Champus Report

## Revisions in Administration Of The IDPA Drug Formulary

**DRUGS AND THERAPEUTICS**—ISMS staff has received inquiries from IDPA recipients regarding recent changes in the IDPA Drug Formulary.

Specific drug products are available only to Public Aid recipients eligible for benefits under the IDPA Basic Health Protection Plan. Recipients eligible for IDPA benefits under the Basic Health Protection Plan include the categories of AFDC MANG Adults, GA and AMI. Physicians may obtain a copy of the listing of reimbursable drug products included in the IDPA Drug Formulary for these categories of recipients from IDPA offices at 931 E. Washington Street, Springfield. It is important to note that prescribed drug products to recipients in these categories will be reimbursed only if: (1) they are prescribed for life threatening situations and (2) they are necessary for maintenance of life.

The Basic Health Protection Plan was developed and implemented by the Illinois Department of Public Aid as one measure to reduce its cost for administering the IDPA Medical Assistance Program. The service and drug product limitations for the Basic Health Protection Plan were not endorsed by the Illinois State Medical Society. However, the ISMS Committee on Drugs and Therapeutics vigorously supported implementation of the prior approval mechanism and special authorization procedures to ensure that physicians could continue to prescribe the appropriate drug products necessary to achieve and maintain successful medical results.

Physicians should instruct recipients to refer questions about program limitations or benefits to their IDPA case worker or local Public Aid office. Recipients should *not* be instructed to contact ISMS about the effects of this IDPA program as it relates to program limitations or benefits.

**BASIC HEALTH PROTECTION PLAN DRUG PRODUCTS**—This column has carried information on the prior approval mechanism for prescribing drug products that are not included in the IDPA Drug Formulary. Additionally, physicians have been informed of IDPA's intent to discontinue providing coverage after November 15, 1982, for life maintenance drug products that were previously authorized for recipients eligible under the Basic Health Protection Plan.

Effective November 15, 1982, IDPA recipients in these affected categories will continue to be eligible to receive those life support drug products *only if the physician obtains a special authorization from IDPA*.

When the physician believes that changes from the patient's prescribed drug product to other products in the IDPA Drug Formulary will cause an adverse medical affect, he/she should request immediate special authorization from the Department by telephoning the IDPA Drug Product Unit at 1-800-252-8937.

This special authorization will be effective only for those recipients in the categories mentioned above who were: (1) IDPA eligible as of July 31, 1982; and (2) receiving one of these life maintaining drug products since that date. The special authorization is a one time only approval and it need not be renewed once it has been granted by the Department.

However, recipients who do not meet the criteria mentioned above for the Basic Health Protection Plan *will not* be eligible to obtain special authorization to continue to receive those life maintenance drug products that IDPA deleted from the Drug Formulary on November 15, 1982. Drug products not included in the benefit package for these recipients may be approved *through the prior approval mechanism*. *Those drug products that are not reimbursable by IDPA through special authorization or prior approval become the responsibility of the patient for payment purposes.*

Physician requests for special authorization *must* be submitted in writing to:

Illinois Department of Public Aid  
Pharmacy Unit  
Post Office Box 4037  
Springfield, Illinois 62708



Additionally, special authorization requests must include the following information:

- (1) recipient name and address;
- (2) recipient individual identification number;
- (3) recipient case identification number;
- (4) name of the drug product for which special authorization is being requested; and
- (5) physician mailing address.

The physician's address is required to facilitate a prompt response by IDPA to confirm special authorization.

Physicians who have questions or require additional assistance in obtaining special authorization may contact the IDPA Drug Unit (toll free telephone number 1-800-252-8937). *Patients who have questions regarding IDPA benefits for drug products should be advised to contact their local IDPA office for assistance.*

**REQUEST FOR PROPOSAL**—At the Governor's Medicaid Conference in August, several provider groups offered suggestions to IDPA for improving the Medical Assistance Program in Illinois. The concept of prepaid capitation plans was among suggestions offered to the Department.

Recently, the Illinois Department of Public Aid released a Request for Proposal (RFP) to provide a full service medical capitation program for IDPA recipients. The Department proposes in its RFP to reimburse these plans on a prepaid capitation basis. Any proposal that is submitted to IDPA for consideration must include a provision to provide all hospital, medical and pharmaceutical care that is normally rendered to IDPA recipients who would receive care under this proposed plan.

It is important to note that the Illinois State Medical Society has neither endorsed nor opposed the Department's Request for Proposal. The ISMS has urged that the implementation of any prepaid capitation plan not be considered as the only alternative to restructuring the Medical Assistance Program in Illinois.

ISMS will continue to negotiate with IDPA on behalf of its members to study other alternative proposals for restructuring the Medical Assistance Program prior to identifying one particular alternative that IDPA may want to adopt.

There are, however, several aspects of the current Request for Proposal that should be clarified for ISMS members.

Subsequent to concerns raised by the ISMS leadership, the Illinois Department of Public Aid has assured the Society that implementation of any prepaid capitation plan will not eliminate the need to continue the existing fee for service health care delivery system. In other words, patients who currently receive medical care from a physician will not be assigned to receive medical care from an IDPA sponsored prepaid plan. In addition, recipients who choose to enroll in a prepaid plan will be able to opt out of such a plan and return to the traditional fee for service system.

IDPA intends to conduct educational programs to explain the health care options that will be available to public aid recipients who choose to join an IDPA sponsored prepaid health care plan. The Department believes that the Request For Proposal will effect approximately 10% of the total IDPA recipient population over an 18 month period of time.

Physicians who are interested in obtaining a copy of the IDPA Request for Proposal or who have specific questions regarding the RFP may contact Mr. Joseph Adduci, Coordinator—Prepaid Health Care Project at 312-793-4295 or write to the IDPA offices at 624 S. Michigan Ave., Chicago, Illinois 60605.

**THIRD PARTY PAYORS SEEK CONSULTANTS**—ISMS occasionally receives requests from governmental and private third party payors in Illinois to have physicians serve as medical consultants to the carrier. The physician consultants assist the third party carrier's medical director in reviewing and identifying certain new types of medical procedures that are unique to a particular medical specialty. The physician consultant may also be asked to assist in reviewing physician claims to determine the medical necessity of a particular medical specialty. The physician consultant may also be asked to assist in reviewing physician claims to determine the medical necessity of a particular procedure or service rendered to a recipient or beneficiary of that third party carrier.

If you are interested in assisting any third party carrier by serving as a medical consultant, please call your ISMS field representative or write to ISMS at 55 East Monroe, Suite 3510, Chicago, Illinois 60603, ATTENTION: Professional Relations. ISMS will maintain a listing of physicians who are willing to serve as consultants to third party payors and may contact you when ISMS has been requested to furnish names of physician consultants. If you are interested in serving as a medical consultant, please identify your medical specialty and include a copy of your curriculum vitae in your correspondence to ISMS.

Physicians who have any questions or require assistance with IDPA, EDS-F or other third party payors may contact their ISMS Field Representative at 312-782-1654.





NOT TO CIRCULATE

**NOT TO CIRCULATE**



